DIRECT-TO-CONSUMER PHARMACEUTICAL ADVERTISING: CONTEXT AND MEANING IN OLDER WOMEN'S LIVES

By

JUDITH JOPLING SAYRE

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2003

ACKNOWLEDGMENTS

Completing a project such as this dissertation, especially at this stage in one's life, presupposes a large cast of patient supporters. Let me briefly attempt to thank those whose belief and encouragement made this study possible.

Dr. Deborah Treise, my chair, mentor, and friend, truly encouraged and supported me throughout my academic career. She first introduced me to the qualitative paradigm and helped me explore its application to those questions of aging and health-related communication that truly interest me. Later, as my chair, she encouraged, assisted, advised, and, occasionally, prodded me to stay on track throughout the entire process.

Drs. Kim Walsh-Childers, Michael Weigold, and Donna Berardo were ideal committee members. Their advice and suggestions were always timely and invaluable. I also would like to add that without the initial encouragement of Dr. Marilyn Roberts, Dean for Graduate Studies, I might never have begun this endeavor. Finally, like so many others who have completed a graduate degree in the College of Journalism and Communications, I want to acknowledge the unflagging–and unflappable–help provided by Jody Hedge, Program Assistant in the Division of Graduate Studies and Research.

This qualitative study would not have been possible without the gracious participation of the women of northeast Florida who so generously made available their time, shared their opinions, and, in the interviews, opened their homes to this researcher. This study truly is their story.

Finally, before any valid qualitative research can be accomplished, the researcher must acknowledge her own personal history, developing an understanding of the factors influencing her research perspective. My interest in and understanding of issues surrounding health-related communication have been immeasurably enriched through countless discussions with my husband and best friend, Jerry W. Sayre, M.D.—a consummate physician communicator. His love and encouragement have been a constant source of strength. Additionally, any accomplishments of mine have been built on the values established by my parents, Wallace and Miriam Jopling. For almost 60 years, their loving support and faith have been a source of strength to many. Their values continue through future generations; I am fortunate, indeed, that my children and grandchildren have been so encouraging and patient during a project that often kept me from participating in their lives as much as I would have liked.

Finally, I would like to acknowledge two individuals who, although not here among us, were immeasurably influential to me. The first is my grandmother, Sara Lovett Jopling, a lady who instilled in me a love and respect for the traditions of oral history. The second is my dear friend, Helen Aller, who first believed that I truly could complete a project begun so long ago.

TABLE OF CONTENTS

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

DIRECT-TO-CONSUMER PHARMACEUTICAL ADVERTISING:
CONTEXT AND MEANING IN OLDER WOMEN'S LIVES

By

Judith Jopling Sayre

May 2003

Chair: Deborah Treise, Ph.D.
Major Department: Journalism and Communications

This qualitative study used a triangulation of methodologies—in-depth interviews, focus groups, and observation—to investigate the context and interpretation of direct-to-consumer (DTC) pharmaceutical advertising in the lives of a group of 43 women older than age 65. Study participants were selected because they fit within the parameters of a key target of DTC advertising—older female consumers. The theoretical grounding of this study in a symbolic interactionism perspective helped provide an enhanced understanding of three broad research questions: (1) How do older women use this form of advertising to create and evaluate their sense of personal health? (2) How do older women use group health-related norms in constructing meaning for DTC advertising? (3) How do older women incorporate DTC advertising in their interactions with their physicians? Analysis of the transcribed discourse, augmented by observational data, revealed ten emergent themes grouped into three general areas: personal health issues, social themes related to DTC advertising, and themes related to specific areas of

DTC advertising. While women of all ages reported markedly similar agreement in their interpretation of the concept of "good health," differences emerged between the respective cohorts of younger (65-75) and older (>75) women. Younger women were much more likely than older women both to discuss DTC advertising with referent group members and to discuss an advertised drug with their physician. Women who expressed negative opinions of DTC advertising also showed age-related differences, with the older women reporting disapproval of the entire concept of DTC advertising, claiming that such a request interfered with the traditional patient-physician role. Younger women who disapproved of DTC advertising reported concerns that this form of advertising was making a negative societal impact through the manipulation of increasingly large numbers of people into seeking medications for problems better solved through lifestyle changes. Finally, study participants of all ages reported problems related to difficulty of reading copy because of small copy size. In addition, no participants voluntarily attended to the "brief summary" page of any ad unless directed by the researcher. Implications for these findings for the pharmaceutical industry, advertising agencies, and regulatory bodies are discussed.

CHAPTER 1
INTRODUCTION AND PURPOSE OF STUDY

> Consumers are notorious for not being able to identify their needs and wants for drug products. They often do not want to give their real reasons for their health behaviors. Many times they want to repeat what they hear in the media about correct health habits. Political correctness reigns. I am not saying do not talk to consumers. What I am saying is take what they say with caution and do not suspend good marketing judgment. (Erlich, 2001, p. 10)

Overview

More and more patients are requesting drugs from their physicians in much the same way they shop for shoes—by brand name (Freudenhaim, 1998; Hollon, 1999; Huang, 2000; McInturff, 2001). "Just prescribe it," rather than Nike's "Just do it," has become a new dynamic in patient-physician relationships (Bell, Kravitz, & Wilkes, 2000; Johnson & Ramaprasad, 2000; Wilkes, Bell, & Kravitz, 2000). Direct-to-consumer (DTC) pharmaceutical advertising is a driving force behind this increasingly consumerist approach to prescription medication. Between 1997 and 2001, DTC pharmaceutical advertising increased 145%, reaching $2.7 billion in 2001(U.S. General Accounting Office, October, 2002, p. 3). DTC advertising has been cited as a major cause of increasing health care costs (Pear, 2001b; Peterson, 2002), patient over-medication (Hollon, 1999), and even a deterioration of the traditional patient-physician relationship (Dalzell, 1999; Kravitz, 2000). Debate on the usefulness of DTC has been intense, with views ranging from the argument that DTC informs and educates consumers to calls for a curtailing of FDA approval of current marketing practices.

The effect of DTC advertising on consumer behavior, that is increasing requests for branded drugs, is unquestionable. In a review of the factors affecting the growth of prescription drug spending, a study by the National Institute for Health Care Management Foundation (NIHCM) noted that the growth in spending has been most noticeable in a few therapeutic categories of heavily advertised drugs (McCarthy, 1999b). For example, this study noted that consumer spending on heavily advertised oral antihistamines such as Claritin, Zyrtec, and Allegra increased by 612% percent between 1993 and 1998. According to a recent study by the NIHCM Foundation (2002), the effect of increased spending on advertised drugs is continuing to be a major factor in the rising cost of drugs. For example, in 2001 half of the $22.5 billion increase in spending on prescription drugs in 2000 was driven by increases in sales for just 34 drugs, including such heavily advertised drugs as Lipitor, Zocor, Vioxx, Celebrex, and Prevacid.

In spite of the overwhelming evidence that DTC advertising is effective, few nonproprietary studies have been found to examine the effect of DTC ads on consumer interpretation of health information imbedded in these marketing messages. Candid pharmaceutical industry executives claim that, while the ads increase disease awareness and promote patient-physician communication about advertised diseases, the ads do not—and are not intended to--provide educational meaning. Dr. Sharon Levine, associate executive director of the Permanente Medical Group, admits that

> Most of direct-to-consumer advertising is promotional. It does what it is expected to do—it raises brand awareness . . . but it does not educate. (Fox, 2001)

More importantly, from the standpoint of this study, no qualitative studies were found that attempted to increase understanding of the meaning of these ads for older

target audiences. One empirical study that did examine how elderly people processed information from DTC advertising concluded that

> situational differences, such as different levels of involvement, may determine whether elderly individuals are more likely to give careful consideration to information presented in an advertisement or to be influenced by the promotional aspects of the advertisement. (Christensen, Ascione, & Bagozzi, 1997, p. 1596)

In other words, "situational differences," the multi-hued and textured contexts of elderly persons' lives, may provide a greater understanding of how this segment of the population integrates and constructs meaning for these DTC advertising messages.

Opponents of DTC advertising agree with the statement that the primary goal of this advertising is to increase drug sales, not to inform and educate the public (Hollon, 1999), that DTC often misleads the public (Kravitz, 2000; Newman, 2000), and that DTC leads to inappropriate over-medication (Tanner, 2001). The economic impact of DTC advertising is an increasingly volatile issue as politicians and economists debate Medicare's coverage of prescription medication for the rapidly growing elderly segment of the population (NIHCM, 2000; Pear, 2001a). Physicians, especially, view DTC advertising skeptically. Hollon, in a 1999 *Journal of the American Medical Association* editorial, responds that

> Reckoning the costs, economic and otherwise, the public health value of DTC marketing is negligible. Moreover, the effects of DTC marketing are undesirable. Most important, by creating consumer demand, DTC marketing undermines the protection that is a result of requiring a physician to certify a patient's need for a prescription drug. (Hollon, 1999)

Proponents of DTC advertising, however, claim that it has resulted in a more informed pharmaceutical consumer and has provided a useful communication cue, prompting patients to initiate discussions with their physicians. Alan Holmer, president

and chief executive officer of Pharmaceutical Research and Manufacturers of America, claims that

> (DTC) advertising is an excellent way to meet the growing demand for medical information, empowering consumers by educating them about health conditions and possible treatments. By doing so, it can play an important role in improving public health. (Holmer, 1999, p. 380)

Importantly, both of these conflicting positions are based on assumptions gleaned from a small number of nonproprietary empirical studies relying on a relatively limited consumer database. A disturbing corollary to these studies is the corroborating evidence suggesting that DTC advertising targeted to physicians, another key audience, also is more promotional than educational. These studies (Herxheimer, Lundborg, & Westerholm, 1993; Hollon, 1999; Stryer & Bero, 1996; Wade, Mansfield, & McDonald, 1989) have refuted the educational value of physician-directed DTC ads, citing lack of original data, missing warnings, and including more promotional than educational material.

As noted above, none of these studies are attempting to explain the contextual impact of these drugs within the specific constructed realities of elderly peoples' lives. DTC advertising targeted to older people is of particular concern for several reasons:

- Older people, who often have multiple chronic health conditions, are more likely to be taking multiple medications in often complex dosage regimens For example, individuals age 65 or older in commercial health plans take an average 29 prescription medications per year, more than four times the average seven prescriptions per year taken by those younger than age 65 (Haug & Ory, 1987).
- Opportunity for negative health outcomes from medication interactions increases with the number of prescriptions taken (Ham & Sloane, 1992, p. 198). Wilkes, Doblin, and Shapiro (1992) found that almost one fourth—23.5%—of Americans aged 65 or older receive at least one inappropriate prescription; and
- The out-of-pocket costs for prescriptions for Americans older than age 65 averaged $670 per person per year in 2000 and are expected to increase by 54% by year 2020 when almost 54 million Americans are projected to be in this age

group (Administration on Aging, 2001). Although older individuals are spending a larger portion of their incomes to obtain DTC-advertised prescription drugs, no studies have been found that have attempted to increase understanding of the meaning of these messages for this target group.

At the public health level, the issue of DTC pharmaceutical advertising targeted to older adults has two major societal implications. The first is the need for a greater understanding of the role of health care information within the lives of the increasingly large percentage of the population older than age 65. In addition, the economic implications of DTC–influenced drug purchasing behaviors by this growing population segment are creating significant economic and political impacts, which only can be expected to become more pronounced as this population increases with the aging of the baby boom generation. At this writing, the issue of prescription drug coverage for Medicare beneficiaries is a topic of intense public debate. Medicare costs, currently 2.3% of national income, are expected to rise to 4.4% by 2030. With a Medicare prescription drug benefit, Medicare's costs would rise to 6.5% of the budget by 2030, a tripling of the program's current costs (Samuelson, 2000).

The salience of these issues suggests the need for studies to increase our understanding of how this population group constructs meaning from DTC pharmaceutical advertising. This qualitative study uses a triangulation of methodologies—observation, multiple in-depth interviews, and a series of focus groups—to provide enhanced understanding related to three broad research questions.

First, responses to the general question 'What do these ads mean to you?' provide increased understanding of the meaning of this form of advertising relative to the way elderly people create and evaluate their sense of personal health. Second, answers to the question "Do elderly people (a) use referent group health-related norms in constructing

meaning for DTC advertising, and (b) use DTC advertising as an information source when discussing health-related topics in their referent group interactions?" provide important insights into issues related to how elderly people use DTC advertising information in their interactions with others. Third, this study investigates how elderly people incorporate DTC ad information into their interactions with their primary care physicians.

Analysis of data resulting from multiple methods used in this study provides enhanced understanding of how the fastest growing segment of our population interprets and assigns meaning to this proliferative, yet still controversial form of advertising.

Problem

Most individuals older than age 65 have at least one chronic condition; many have multiple conditions (Ham & Sloane, 1992). The most frequently occurring conditions or illnesses for older people include arthritis (49%), hypertension (36%), hearing impairments (30%), heart disease (27%), and cataracts (17%) (p. 9). Some of the most heavily advertised (by dollar volume) prescription medications in this country reflect many of these conditions in this target population (Drug Benefit Trends, 2000; Drug Topics Archive, 2001; Latner, 2000).

For example, during the first year after its launch in 1999, the arthritis medication Celebrex generated 17 million new and refill prescriptions or 62% of total new drug costs (Rosenberg, 2000; Drug Benefit Trends, 2000). That same year Celebrex reached sales of $1.4 billion with an initial marketing budget of an estimated $25 million. Merck & Co. followed with a more than $81 million 1999 promotion for Vioxx (Rosenberg, 2000), another COX-2 inhibitor, anti-inflammatory arthritis medication. Two additional major pharmaceutical marketing successes, Viagra (for male erectile dysfunction) and Lipitor

(elevated cholesterol treatment), also are frequently prescribed to older patients. The effectiveness of these advertising campaigns has been dramatic. When Pfizer increased consumer advertising for Lipitor by more than $45 million in 1999, sales of the drug jumped to $2.7 billion, an increase of 56% (Belkin, 2001). After back-to-back successes with Celebrex (arthritis medication), Lipitor (cholesterol reduction), and Viagra (for impotence, or the more consumer-friendly term, erectile dysfunction—'ED'), Pfizer was named "Marketer of the Year" in 2001 by *Advertising Age* magazine (Goetzl, 2001).

The rapidly rising costs to older adults for prescription medications partially are a reflection of the rising number of prescriptions written for this population (NIHCM, 2001). Physicians are seeing more patients for heavily advertised conditions, are receiving more requests for brand name prescriptions (NIHCM, 2002, U.S. General Accounting Office, 2002), and are more likely to honor patients' requests for advertised medications (Mintzes et al., 2002; Prevention, 1997). In addition, newer drugs tend to cost more than older medications, and there is an escalating trend of providing treatment for new "lifestyle" diseases, such as ED. The "lifestyle" category of prescription drugs are those frequently expensive medications prescribed for conditions that often are chronic and, although inconvenient, embarrassing, or uncomfortable, are not life-threatening. Other examples of this class of medications are Propecia to prevent hair loss, Renova for face wrinkling, and Lamisil for toenail fungus. The National Institute for Health Care Management Foundation reported in May 2001 that spending on medications administered in an outpatient, or non-hospital setting, increased 19% between 1998 and 1999 (Pleming, 2001), following a 17% increase for the previous year (Pear, 2000).

Concern over these medical costs and their effect on Medicare expenses was a major issue in the 2000 elections. Both candidates made prescription drug coverage for seniors a major part of their platform. Yet by the summer of 2002, no agreement on drug plans had been reached. Republicans and Democrats, in attempting to garner the senior vote in upcoming mid-term elections, each increased offers to reduce out-of-pocket expenses for prescription drugs and to cap total expenditures. For example, Senate Republicans called for a plan that would cost the elderly $35 per month, with the government paying 80% of the first $1,000 of prescription costs, 50% of the next $1,000, and seniors paying the remainder until a cap of $4,500 is reached; the Democratic plans eliminates the deductible, only costs older people $25 a month, but would require a copayment of $10 for generic drug prescriptions and a $40 copayment for brand name drugs (Barry, 2002c). In addition, the Republicans called for a two-year analysis of the marketing impact of DTC advertising on health care costs (Teinowitz, 2002).

Few studies have even examined the content of DTC advertising. One content analysis by Bell and associates (Bell, Kravitz, & Wilkes, 2000) examined trends, medical conditions for which the drugs are most commonly promoted, and type of appeals used, noted the dramatic increase in DTC advertising between 1989 and 1900, the years of the study, and found that the most frequently advertised drugs were for common chronic conditions (allergies), conditions that may not have been previously recognized (toenail fungus), or for conditions that previously were not treatable with prescription medication (erectile dysfunction).

As discussed previously, the existence of new drug therapies for previously non-treated conditions, such as impotence or hair loss, and new prescription drugs for

common chronic conditions, such as allergies, high blood pressure, arthritis and high cholesterol, are driving much of the increased DTC advertising. Some health care professionals have begun to voice concerns that DTC advertising may be changing individuals' definitions of "healthy" behavior. For example, diet and exercise are the recommended first-line therapeutical approach to high cholesterol levels (Creagan, 2001). Many patients, however, prefer to take a pill rather than skip the pizza. One director of pharmacy benefits for a national health plan blames DTC for encouraging patient laziness. "We have patients treating themselves with medications when they could modify their lifestyles and achieve the same results" (Dalzell, 1999).

Other concerns related to DTC advertising focus on the nature of the interpersonal interactions occurring when a patient visits his or her physician's office. Physicians' fears that DTC advertising creates a "misleading, biased view" of drugs (Lipsky & Taylor, 1997) are magnified by some studies indicating that patients, if denied a requested advertised prescription medication, would be sufficiently disappointed to switch doctors (Bell, Wilkes, & Kravitz, 1999). An early empirical study (Petroshius, Titus, & Hatch, 1995), found that physicians' attitudes towards DTC advertising are based on age, experience, practice setting, and speciality area, with younger, less-experienced physicians in group practices more receptive to patient-initiated discussions of DTC-advertised drugs. This study expands our understanding of the meanings these important interactions have for elderly people.

Theoretical Framework Guiding the Study

This study is grounded in the theoretical constructs of symbolic interactionism, a constructivist theory. The symbolic interactionist ontological understanding of meaning

as socially constructed realities provides an appropriate perspective when attempting to gain greater understanding of the various meanings elderly people may apply to DTC advertising. Lincoln and Guba (2000) explain their interpretation of the constructed realities of the constructivist perspective in which symbolic interactionism is embedded:

> We do not believe that criteria for judging either "reality" or validity are absolutist, but rather are derived from community consensus regarding what is "real," what is useful, and what has meaning (especially meaning for action and further steps). We believe that a goodly portion of social phenomena consists of the meaning-making activities of groups and individuals around those phenomena. The meaning-making activities themselves are of central interest to social constructionists/constructivists, simply because it is the meaning-making/sense-making/attributional activities that shape action (or inaction). (p. 167)

Symbolic interactionism, "the study of how the self and the social environment mutually define and shape each other" (Lindlof, 1995, p. 40), provides a strong theoretical base for understanding not only how elderly people define and create meanings for DTC advertising, but also for exploring how this population uses referent group health-related norms in their evaluation of DTC advertising and as an information source when engaging in referent group interactions. Finally, the dramaturgic implications of symbolic interactionism, as developed by Erving Goffman (1959) and discussed in the following chapter, provides insight into the interactions between the essential message of DTC advertising—urging formerly passive patients to take an active role in requesting specific medications—and the traditional role of the patient.

Interpreters of symbolic interactionism, developed at the University of Chicago during the 1930s by social psychologist George Herbert Mead (1934), claim that it is through the process of social communication that individuals develop the concept of "self." In defining this concept, Mead explained:

> The individual experiences himself as (an object), not directly, but only indirectly, from the particular standpoints of other members of the same social group . . . (The individual) becomes an object to himself just as other individuals are objects to him . . . it is impossible to conceive of a self out of social experience. (pp. 138-40)

George Horton Cooley (1902/1964), a contemporary of Mead, referred to this process as creating the self "as through a looking glass" (p. 184). Each person's self-image depends on the reflections provided through his or her daily social interactions with others. This concept of self is never static. Each person's narratively constructed self is "conditioned by working senses of what we should be at particular times and places" (Holstein & Gubrium, 2000, p. 3).

As people age, their self-images must adjust to a variety of physical, psychological, and social changes. One textbook on geriatric care for primary care physicians acknowledges that

> it is rare for a person to reach age 80 without one or more chronic disabling conditions. In addition, significant psychological and social losses accompany advancing years. Retirement, illness in a spouse, geographic separation from family members, relocation from a beloved home into a smaller apartment or retirement community, and many other common events during these years all represent losses. (Ham & Sloane, 1992, pp. 26-27)

Understanding the meaning elderly people apply to proliferating DTC advertising messages provides a greater understanding of how people incorporate health changes into their self-image and how they reflect them in their social interactions with family, friends, and physicians.

It is important to acknowledge the essential scope of this qualitative study. While it is hoped that this study sheds light on how older people create consensual meaning for DTC advertising, it must be emphasized that the symbolic interactionist paradigm is antifoundational; "it is not intended to explain a universal, ahistorical mechanism for

behavior"(Lindlof, 1995, p. 57). This study is designed to provide useful insights into the meanings participants construct for DTC advertising based on their interactions with others. In addition, this study examines how an elderly person's social interactions with his or her family, friends, and physicians is shaped by the meaning he or she applies to this form of advertising.

Overview of Chapters

Chapter 2 is a literature review discussion organized according to the various factors influencing the response of the target audience to DTC pharmaceutical advertising. The first section is a discussion of the ontological and epistemological appropriateness of a constructivist perspective for increasing understanding of the meaning of DTC advertising in the lives of elderly people. In particular, the symbolic interactionist paradigm provides an insightful perspective for exploring the cognitive and social complexities inherent in older peoples' lives. This paradigm also is useful in enhancing understanding of the multiplicity of changing roles older people face in their interactions with their referent groups and their health care providers. The second section of this chapter examines the economic, historic, and regulatory issues driving the rapid growth of DTC advertising as well as a review of some of the controversies surrounding this form of advertising. The third section of this chapter includes a discussion of older adults' construction of meaning for DTC advertising, along with the relevance of these created meanings for older persons' personal constructions of health, for their interactions with their referent groups, and in their encounters with their physicians. This chapter also discusses information needs of older adults, along with physical and cognitive barriers to acquiring this information. The rationale for selecting

print as the medium of study and the elements of print DTC advertising is presented in the fourth section, followed by the resulting research questions.

The methods used in this study are described in Chapter 3. This discussion includes an explanation and justification of the theoretical perspective in which this study is grounded, a discussion of the issues of trustworthiness, an explanation of participant selection methods, and a description of transcription and data analysis procedures.

Chapter 4, the analysis chapter, presents the results of the study. Included in the discussion is an analysis of participant characteristics and the discussion of the themes that emerged from the analysis.

The summary and conclusions are presented in Chapter 5. This discussion includes the theoretical, methodological, and practical implications of this study along with a discussion of the study's limitations. The summary of key findings and directions for future research also are presented.

The appendices of this study include the research questions, informed consent documents, discussion guides, sample transcripts, and copies of DTC advertisements from the print magazine used as a stimulus.

CHAPTER 2
LITERATURE REVIEW

> Older Americans are bombarded with news about heart disease, stroke, cancer, and other catastrophic ailments. Yet these probably aren't the problems that you and your friends talk about when someone mentions aging. You're concerned about the things you're facing now—the hundreds of little big things that make getting older so difficult. Things like arthritis, bunions, corns, calluses, memory loss, morning aches, shingles, dry mouth, hearing loss, and cold feet and hands. You're concerned about the things that nip away at self-reliance, independence, and self-confidence and threaten to make you feel older than your years. (Dollemore, 1999, p. xi)

DTC advertising has focused overwhelmingly on the class of drugs known "lifestyle" medications—those drugs for chronic conditions such as allergies, arthritis, hyperlipodemia (high cholesterol), and impotence (Bell, Kravitz, & Wilkes, 2000). While not generally life threatening, these conditions tend to impact negatively a patient's quality of life. As discussed in the introductory chapter, since 1997 there has been a tremendous growth in DTC advertising, especially advertising targeted toward older consumers. No studies exist, however, designed to explain how this population group interprets this advertising and assigns meaning to messages imploring them to request prescriptions from their physicians. This study sought to provide understanding of how older people interpret this advertising, how they incorporate information and imagery from DTC ads into their interactions with their referent groups, and how they evaluate the influence this advertising has on their interactions with their physicians.

It should be noted that much of the marketing research related to DTC pharmaceutical advertising is found in proprietary studies conducted by pharmaceutical

companies and advertising agencies and thus not available either to academic researchers or to the interested public. The existing empirical studies, as reviewed in the following sections, are relatively limited in scope and seldom are focused on the population segment targeted most frequently—the elderly. Of even greater concern, related to the focus of this inquiry, is the fact that no qualitative studies have been found that have attempted to broaden understanding of what this advertising means to older individuals' self-image. In addition, no studies have been found that address how the social interactions of elderly people influence their interpretations of these messages or how elderly people use these messages in their interactions with their family, friends, and physicians.

Research in this chapter is organized into four content areas. The first section includes an extension of the discussion of symbolic interactionism, the research perspective directing this qualitative inquiry and introduced in Chapter 1. Particular attention will be given to an examination of such key constructs as *self*, *symbol*, *labeling*, and *joint act*. This discussion also includes an examination of Blumer's "three simple premises" (Holstein & Gubrium, 2000, p. 33) for sufficiency and appropriateness for this study. The methodological implications of this theoretical approach are discussed in Chapter 3. The second section of this chapter is a review of the history, growth, and economic impacts of DTC advertising. The third section provides a broad overview of the specific issues surrounding elderly people and health care including demographics, medical needs of elderly people, health-related social issues, and special communication issues relating to the elderly and health. The fourth section reviews studies on elements of DTC advertising that relate specifically to elderly adults. Research questions and hypotheses are found at the end of this chapter.

Symbolic Interactionism: The Research Perspective

Symbolic interactionism is the study of how the self and the social environment mutually define and shape each other through symbolic communication (Lindlof, 1995, p. 40). Symbolic interactionism, developed at the University of Chicago during the 1930s by social psychologist George Herbert Mead (1934), allows theorists to claim that it is through the process of social communication that individuals develop the concept of "self." Mead, in defining the concept of self, explained that

> The individual experiences himself as (an object), not directly, but only indirectly, from the particular standpoints of other members of the same social group . . . (The individual) becomes an object to himself just as other individuals are objects to him . . . it is impossible to conceive of a self out of social experience. (pp. 138-40)

George Horton Cooley, a contemporary of Mead, referred to this process as creating a self "as through a looking glass" (Holstein & Gubrium, 2000, p. 27). Each person's self-image depends on the reflections provided through his or her daily social interactions with others, and it is the ideas of others that create an individual's social reality.

> The man is one thing and the various ideas entertained about him are another; but the latter, the personal idea, is the immediate social reality, the thing in which men exist for one another and work directly upon one another's lives. (Cooley, 1964, p. 123)

The self, in other words, is "the reflexive beacon of social interaction, not existing separate from, or otherwise transcending, social life (Holstein & Gubrium, 2000, p. 32). This concept of self, moreover, is never static. Each person's narratively constructed self is "conditioned by working senses of what we should be at particular times and places" (Holstein & Gubrium, 2000, p. 3).

Each individual determines, through the use of significant *symbols* (verbal or nonverbal), the intentions of others (Lindlof, 1995, p. 42). For these symbolic gestures to be interpreted, they must become something which, in the mind of the interpreter, stands for the entire act (Manis & Meltzer, 1972, p. 7). In other words, the use of symbols allows an individual to anticipate the other person's response, to imagine what the other person will do. This process of imagining or anticipating another person's behavior allows an individual to take on the *role* of the other, thus imagining herself as she might be seen by the other (Lindolf, 1995, 42). Group behavior, moreover, is possible only when each participating individual attaches the same meaning to the same gesture. Unless interacting individuals interpret gestures similarly, unless they envision the imagined portion in the same way, there can be no cooperative action (Manis & Meltzer, 1972, p. 7). For successful role taking to take place, therefore, "an individual must understand all the roles making up the particular group life" (Lindlof, 1995, p. 42). In order to interpret the meaning of the symbols found in a DTC advertisement, older people must not only imagine the meanings of these symbols for their own health but also must integrate these meanings into their interactions with their referent group members. In addition, the social reality of referent group interactions provides the context in which an elderly individual interprets DTC advertising.

Mead's work was further developed and amplified by Herbert Blumer (1969), who claimed that meaning derives from social interaction and provides the foundation for an individual's acts toward things or other people. Blumer summarized his perception of symbolic interactionism and suggested guidelines for methodological decisions by outlining three "simple" premises. These premises, with their implications for this study are

- "Human beings act toward things on the basis of the meanings that the things have for them." In other words, it is the individual's own personal meaning, not the intrinsic meaning of the symbol itself, that is important. While recognizing that pharmaceutical companies, the FDA, and others have assigned "meaning" to DTC advertising, virtually no studies have been found that attempt to understand the meanings assigned to this advertising by a major target for these messages—the elderly.

- "The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows." This premise has important methodological implications in that it suggests that for optimal understanding, meanings need to be interpreted by direct observation of interactions within the social context of lived experience. This inquiry proposes to study how meanings for DTC advertising messages are assigned and managed within the context of elderly persons' interactions within their referent groups.

- "Meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters." This premise also suggests certain methodological decisions because it implies that the construction of meaning is an ongoing process, developing and being modified by the individual as he/she continually interprets the meaning. In other words, interpretation of meanings cannot be finalized. The use of multiple methodologies, as discussed in Chapter 3, should provide insight into whether meanings assigned by elderly individuals to DTC advertising are modified through the course of the interview or during the focus group process.

In extending paradigmatic development, Blumer acknowledged the importance of group norms in his identification of the *joint act*, the generic form of group behavior produced through the consensual actions of individuals who share a community of symbols (Lindlof, 1995, p. 44). According to Lindlof, this premise suggests that "people align their actions with respect to meanings held in common with others as well as perceived differences with conflicting groups" (p. 43). Lindlof continues to suggest that an individual's range of acceptable behavioral options is determined by these rules and codes, which are "invested with meaning and authority by group members and can be changed through innovative joint action" (p. 44). Erving Goffman (1959) further expanded the meaning of the self in interpersonal relations by adding dramaturgic concepts related to scenes, scripts, roles, and performances. Goffman claims that the

"self does not derive from its possessor, but from the whole scene of his action" (p. 252). This expanded concept is particularly useful when examining how an individual understands her role as a patient when she is engaging in the joint act of patient-physician communication. It also may be an applicable concept when investigating whether DTC advertising, when implicitly or explicitly requesting individuals to "ask their physician" for branded prescriptions, is proposing "innovative joint action," a redefining of the traditional patient-physician role.

The symbolic interactionist position of this study assumes that the meanings ascribed by viewers of DTC print advertisements can be determined only by including a combination of textual and extra-textual factors in the primary context, the moment when a reader is engaged by a text, and during secondary communication contexts, those communication situations or events that occur when a reader attempts to explain to another the meaning he or she has ascribed to the advertisement (Fry, Alexander, & Fry, 1989). When a reader is constructing the meaning of his or her interaction with a text, they are "simultaneously (engaged in) a process of creating, defining, and presenting one's self to others" (Fry et al., 1989, p. 339). Elderly participants in this study have an opportunity to explain their understanding of DTC advertising, in both primary and extra-textual contextual interactions. Participants will explain not only the meaning they ascribe to the DTC ad they've just observed but also the meanings they ascribe to this form of advertising during their interactions with their spouses, family, friends, and health care providers.

For the purpose of this study these textual factors include but are not limited to the language content of the advertisement copy, the photographic and/or design elements of the ad, the interaction of verbal and visual elements, and the particular disease entity

or symptomology addressed by the ad. These textual factors, which may dominate in the primary viewing context, also are accompanied by extra-textual factors such as perceived personal health, health beliefs, social contexts, and historical background relative to drug-requesting and taking. When an older person, in a communication encounter with a physician, bases a prescription request on a DTC drug advertisement, that individual is engaging in a secondary communication context. In this situation, the individual must correlate the request for a drug with the impression the individual wishes to make on the physician. These constructs of textual and extratextual factors are useful when inquiring how an elderly participant feels when asking a doctor about a drug seen advertised or to explain how easy or difficult it is to remember information from a drug advertisement.

Lindlof claims that "[t]he rich possibilities of symbolic interactionism for studying the sites and events of popular communication have not yet been adequately explored" (1995, p. 45), even though symbolic interactionism, with its concepts of socially constructed reality and its acceptance of multiple methodologies, should provide a useful theoretical platform for studies of mass communication. In this literature review, no studies were found that used a symbolic interactionist perspective to study the meanings ascribed by members of a particular target audience to advertising messages. Numerous studies have used this theoretical perspective, however, to examine organizational communication (Lindlof, 1995, p. 45), and a few such studies have investigated organizational interactions in medical settings. For example, one study (Geist & Hardesty, 1990) examined the perspectives of medical professionals as they implemented new reimbursement systems. This study seeks, from the perspective of symbolic interactionism, a deeper understanding of how elderly people manage the

interpretation of DTC advertising and how such advertising is used in the interactions of elderly people with their family, friends, and physicians.

DTC Pharmaceutical Advertising

DTC pharmaceutical advertising is unlike most other forms of consumer advertising in that its intended outcome is not to induce consumers to make a direct purchase, but rather to induce them to request a prescription from their physicians. The U.S. Government Accounting Office (2002) estimates that as a response to exposure to DTC advertising, annually 8.5 million consumers, or approximately 5% of the population, both request and receive from their physician a prescription for an advertised drug (p. 4). The growth in this type of advertising either has provided an "excellent way to meet the growing demand for medical information, empowering consumers by educating them about health conditions" (Holmer, 1999) or it is "not good for patients, physicians, or the public's health" (Hollon, 1999). As will be shown, the polarization and urgency of this debate has escalated in tandem with the rapidly rising costs of prescription medications.

History, Growth, and Economic Impact

A recently released study by the National Institute for Health Care Management Foundation (NIHCM, 2002), a health research organization, reports that retail spending on prescription drugs increased 17.1% from 2000 to 2001, up from $131.9 billion to $154.5 billion (p. 5). This increase is in addition to the previous year's increase of 18.8%. In fact, retail spending on prescription drugs has almost doubled since 1997, when it was $78.9 billion (p. 6). During this same time period, spending on DTC advertising has increased 150% from 1997 until 2001 (Pear, 2002). It should be noted that 1997 was the year the FDA gave approval for the present form of DTC advertising.

The NIHCM report further states that prescription drug spending has risen 15% or more per year for the past few years, representing the most rapidly escalating component in health care costs (p. 2). The report identifies several factors contributing to the rise in prescription drug costs:

- The incidence of many chronic conditions, such as diabetes, elevated cholesterol, and arthritis is increasing, partially due to an aging population.
- Doctors are diagnosing and treating more of these chronic conditions than in the past; 39 percent of the increase in prescription spending over the past year was attributable to an increase in the number of prescriptions written by doctors.
- Newly approved, more expensive drugs are being more heavily marketed to both doctors and consumers.
- Drug companies are extending the "franchise" on their most profitable drugs by spinning off new formulations.
- Managed health plans are covering more of the costs for prescription drugs than in the past. (NIHCM, 2002, p. 3)

According to the study, the increase in spending was largely attributable to the rising volume of sales of the 50 top-selling drugs, with the top 50 selling drugs accounting for 44.4% of total outpatient retail drug sales in 2001 (p. 6). Spending on DTC advertising by pharmaceutical companies increased 150% from 1999 to the $2.7 billion spent in 2001(Pear, 2002). This increase in DTC advertising expenditures appears to be effective. While the rise in pharmaceutical spending has not been conclusively linked to DTC advertising campaigns (NIHCM, 2001), an examination of two recent DTC campaigns for top-selling drugs is useful.

Arthritis and high cholesterol are two chronic conditions that affect large percentages of older people. Almost half (46%) of people older than 65 are affected with arthritis, and more than one-fourth (28%), have cardiovascular conditions in which lowering serum lipid levels is a common treatment modality (Ham & Sloane, 1992).

While many different drugs are used to treat rheumatoid arthritis, nonsteroidal anti-inflammatory drugs (NSAIDS) have both analgesic and anti-inflammatory effects. COX-2 inhibitors are relatively new forms of NSAIDs that reportedly have fewer gastrointestinal side-effects than the older, less-selective drugs in this category (Medical Letter On Drugs and Therapeutics, 2000). Celebrex (celecoxib), one of the two new COX-2 inhibitors (the other is Vioxx, rofecoxib), was the most successful drug launch ever when it achieved sales of almost $1.3 billion in 1999, the year it was introduced. Coproducers Pharmacia and Pfizer were rewarded for the $31.4 million spent on the first-year advertising campaign for Celebrex; the drug generated sales of $2.3 billion in the 12 months ending in March 2001 (Peterson, 2001). Vioxx was launched by Merck with a $17.1 million ad campaign; DTC for the two drugs together account for almost 10% (9.9) of the industry total (Quintiles International, 2001). In a survey by marketing firm Scott-Levin, 30% of consumers reported that they had seen the Celebrex print advertisement; 13% correctly identified the ad. Twenty-two percent of the surveyed physicians noted an increase in patient-initiated discussions about Celebrex, and 78% of these doctors reported that they had heard a request for the drug. It is interesting to note that comparative average costs to the patient for a 30-day treatment at the lowest recommended dosage are $84 for Celebrex, $72 for Vioxx, and $18 for aspirin (average generic price) (Medical Letter on Drugs and Therapeutics, 2000).

Another heavily advertised category of drugs are the cholesterol-reducing drugs known as statins. Two of these drugs, Lipitor and Pravachol, are among the most heavily advertised brands. In 1999, Lipitor sales increased 56% over 1998, and the drug rose to number two in retail prescriptions sold after Pfizer spent $55.4 million on advertising (NIHCM 2001). Lipitor sales continued to rise, making it the top-selling drug in 2001,

with $4.5 billion in retail sales, up 22% from 2000 (NIHCM, 2002). While some physicians claim that increased knowledge about these drugs encourages patient-physician communication about cholesterol levels, other doctors worry that patients will be only too enthusiastic about skipping the first level of defense against high cholesterol—diet and exercise—and insisting on going straight to a pill (Belkin, 2001).

As extensive as spending on DTC advertising has become, it is still less than one-third (27%) of the $6.6 billion pharmaceutical companies are spending annually to promote their products. Sampling alone, the practice of leaving "free"[1] samples in physicians' offices, had an estimated retail value of $3.9 billion in 2000 (Drug Topics Archive, 2001). Direct selling to physicians (detailing), spending on meetings and events, and direct mail and journal advertising targeted to doctors combined for another $2.7 billion in 2001. The most common media for pharmaceutical advertising to physicians has long been extensive advertising in medical journals. Just as pharmaceutical advertising to consumers is coming under closer scrutiny, physicians are beginning to examine critically the content of journal advertising. Several studies, for example, have suggested that much of this advertising provides limited, or even faulty, information. A content analysis of advertisements in medical journals of 18 countries found that in more than half the 6,700 advertisements surveyed, important warnings and precautions were missing (Herxheimer et al., 1993). Wade, Mansfield, and McDonald (1989), in a study of the evidence supporting marketing claims, concluded that advertising claims were based on inadequate standards of evidence. Physician groups are reporting greater

---

[1]A recent empirical study of prescription drug promotion and physicians' behavior (Gonul, Carter, Petrova, & Srinivasan, 2001), found that samples left in physicians' offices for distribution to patients have a positive and informative effect, especially on physicians with relatively large numbers of Medicare patients.

sensitivity to the ethical issues involved in allowing pharmaceutical marketers not only to fund but to create educational materials for continuing medical education (Ferguson, 2000; Relman, 2001) and to provide gifts to physicians (Steinman, 2000).

DTC, however, continues to be the fastest growing area of pharmaceutical promotion. The following section will examine the regulatory forces that have driven this explosion in advertising.

Regulatory History of DTC Pharmaceutical Advertising

Pharmaceutical advertising to the consumer is a relatively recent phenomenon. In fact, the United States, along with New Zealand, is one of only two countries to allow the practice. Prior to the early 1980s, pharmaceutical marketing efforts were targeted almost exclusively to physicians, who served as "learned intermediaries," interpreting medical information and dispensing prescriptions to relatively passive patients (Gemperli, 2000).

The concept of "learned intermediary" derived from a 1966 lawsuit in which a drug manufacturer was sued for failing to warn physicians of potential side effects *Sterling Drug v. Cornish* (1966). The courts ruled that pharmaceutical companies had a duty to warn physicians about potential adverse side effects. Physicians would then advise patients accordingly (Gemperli, 2000). The majority of advertising, therefore, was directly primarily to the physician. This concept was significantly modified in 1999 in the landmark case of *Perez v Wyeth Laboratories*. This case was brought by a group of women who claimed that Wyeth Laboratories had failed to provide adequate warnings about the potential risks of the Norplant contraceptive system. On appeal, the Supreme Court of New Jersey ruled that shortened medical visits, "lifestyle" prescription drugs, and extensive DTC advertising had "significantly diminished" the physician's role (Gemperli, 2000). Companies conducting DTC pharmaceutical marketing, according to

this ruling, were legally responsible for including adequate warnings about the potential side effects and risks of their product.

Since 1962, regulatory oversight for DTC advertising has been the responsibility of the US Food and Drug Administration (FDA) (Kessler & Pine, 1990). In 1962, acting under the Kefauver-Harris Amendments to the Federal Food, Drug, and Cosmetic Act, the FDA ruled that pharmaceutical advertisements must contain the following:

> (1) The advertisement cannot use a . . . name for the drug or any ingredient to imply that the drug has some special effectiveness when the drug or the ingredient is a common substance with recognized limitations. (2) The established name of the drug must be used in conjunction with the proprietary name given the drug; (3) Advertisement and promotion of a drug must be "fairly balanced" between information relating to side effects and contraindications and information relating to effectiveness; (4) An advertisement must include a "brief summary of the package insert disclosing the side effects, contraindications, and effectiveness of the product. (Carr & Bowers, 2002, p. 24)

Soon after drug companies began tentative DTC marketing in the early 1980s, the FDA placed a voluntary moratorium on the practice. This moratorium was lifted in 1985 (Bell, Kravitz, & Wilkes, 2000). While DTC advertising increased, it was still confined largely to print media outlets—newspapers and magazines. This restriction on media was primarily due to the FDA's requirement that all DTC advertising contain a "brief summary" of the drug's risks (Castagnera & Gerner, 2000). Although advertising requirements were somewhat more lenient than FDA labeling requirements, full compliance was anything but "brief." Advertisements were required to balance the risks and benefits of the drug and include the contraindications associated with the drug. They also had to meet additional requirements, including:

> (1) trade name, (2) the label must contain a "brief statement" listing the warnings, side effects, contraindications, and precautions, (3) the label must describe the drug's components, and (4) the label must include a formula or chart showing the quantity of each ingredient. (Castagnera & Gerner, 2000, p. 139)

Provision of this information in the time constraints of television and radio is virtually impossible. In August 1997 the FDA changed its regulations, issuing a draft proposal that allowed manufacturers to include broadcast advertising in the campaign marketing mix as long as these channels included "adequate provision" of information about major risks associated with the drug (Carr & Bowers, 2002, p. 21). When this proposal was made permanent in August of 1999, the FDA also suggested, but did not require, that pharmaceutical manufacturers provide nonpromotional product information, and noted that it was evaluating regulations as they applied to DTC print advertising. In addition, broadcast media were required to include:

> A toll-free number, (2) a reference to DTC print advertisements, (3) an Internet web page address, and (4) a statement that directs consumers to physicians and/or pharmacists for additional information about the product. (Terzian, 1999, p. 150)

Now that regulations have been loosened, DTC television ads literally have blanketed the channels, currently accounting for the majority--$1.1 billion—of total DTC spending (NIHCM, 2001). Virtually all of these ads refer to one or more of the information sources above. With FDA regulations, therefore, requiring print media to carry the major informational content of DTC campaigns, what type of information and appeals, and in what format, appear most often?

Considering the economic impact of DTC pharmaceutical advertising, relatively few content analyses have been conducted of DTC content. A 1996 study that examined DTC print advertisements for categories of advertised drugs and information content noted that the most heavily advertised brands were market leaders within their respective therapeutic classes, were targeted to a broad patient base, and primarily were new drugs developed to treat common chronic diseases (Roth, 1996).

A recent content analysis (Woloshin, Schwartz, Tremmel, & Welch, 2001) of 67 different DTC ads in ten broad interest magazines measured only the general content copy, not the information in the brief summary written in small print, and found that product benefit was provided only in vague "qualitative" terms and few ads provided supporting evidence. In contrast, almost two-thirds (67%) of the advertisements made one or more emotional appeals to readers, with the most prevalent appeal being a claim to help the reader "get back to normal again" (p. 1144). Finally, it should be noted that the authors concluded that DTC advertisements appear most frequently in magazines designed for women.

A content analysis conducted by Bell, Kravitz, and Wilkes (2000) noted that new advertisements and brand introductions increased dramatically during the decade 1989-1998. A content analysis of drug advertisements appearing in 18 consumer magazines revealed that the majority of the advertised drugs were for common chronic conditions (allergies), conditions that might not have been recognized by the consumer as even treatable prior to reading the advertisement (toenail fungus), undertreated conditions (depression), and conditions that previously might not have had available and/or effective treatment options (erectile dysfunction). Very few ads were observed for acute conditions (antibiotics) or inpatient-administered medications (cancer chemotherapy drugs). Of especial interest are the appeals used in the ads: "effective" was most frequent (57%), followed by "controls symptoms" and "innovative" (41% each), "prevents" condition (16%), "powerful" (9%), "dependable" (4%), and "cures" (3%). The most frequently used ease-of-use appeal was "convenience" (38%) (p. 333).

A survey conducted by these same authors found that many respondents (21% to 43%) had erroneous views about the role of the FDA in regulating drug advertising,

believing that the FDA prescreens and thereby "approves" the ads. Moreover, those who held the most positive views of the value of DTC ads were most likely to be uninformed about regulation (Wilkes et al., 2000). The reality is that the FDA is legally not allowed to require preclearance of ads (Belkin, 2001). According to Nancy Ostrove, a branch chief within the FDA's Division of Drug Marketing, Advertising, and Communication, FDA employees "allow a certain degree of puffery, but we don't allow overstatement of effectiveness or minimization of the risks" (Belkin, 2001, p. 35).

The following section illustrates that there is a significant opinion among some health care providers that the public confidence in DTC advertising noted by some studies may not always be warranted.

Controversies in DTC Advertising

Editorial debate on the relative values of DTC drug advertising has escalated among the various sectors of the medical community, the FDA, the advertising industry, the pharmaceutical industry, and politicians. While some claim that DTC advertising informs and educates consumers (Elliott, 2001; Kahn, 2001; Peyrot, Alperstein, VanDoren, & Poli, 1998) and allows consumers to make better health care choices (Holmer, 1999; Johnson & Ramaprasad, 2000; Kahn, 2001), others claim that it confuses consumers (Kravitz, 2000), interferes with the physician-patient relationship (Bell et al., 1999; Hollon, 1999), and is leading to an overmedicated society (Elliott, 2001). The following sections examine two of these issues: the evidence related to communicating benefit/risk information to consumers and the effect of DTC drug advertising on the patient-physician relationship.

Communicating risk information. While empirical studies of DTC pharmaceutical advertising content are limited, anecdotal evidence, including reports

from the FDA, express concern over the lack of accuracy of the information presented, especially in the area of risk. Thomas Abrams, director of the FDA's Drug Marketing, Advertising, and Communications, reports that while the FDA regulations generally have been effective, misrepresentations do occur:

> What we have found is that the most common violations are not adequately presenting risk information—not presenting a candid representation of the risks of drugs—and overextending who the drug is for—over-promising for more than the indicated population. (Newman, 2000, p. 964)

The FDA does have pharmaceutical companies pull from circulation ads that are found to be misleading. For example, initial ads for Celebrex displayed actors posing as arthritis patients performing strenuous activities such as rowing. In addition, the audio portion of these ads claimed that Celebrex offered more and longer pain relief from osteoarthritis pain and stiffness than was warranted by evidence (Belkin, 2001). More recently, physicians received a letter from Pharmacia, manufacturer of Celebrex, that was sent due to an FDA ruling (Pharmacia letter to physicians, April 2001). This letter states in part:

> Specifically, the FDA has objected to claims and promotional activities by or on behalf of Pharmacia that minimized the potentially serious risk of significant bleeding. . . . Additionally, the FDA has objected to claims and promotional activities that: minimized the contraindication of Celebrex in patients who have demonstrated allergic-type reactions to sulfonamides; omitted important risk information; promoted Celebrex for unapproved uses; and, made unsubstantiated comparative claims. Therefore, the FDA has requested that we correct these promotional messages accordingly.

Adequate inclusion of risk information is only one part of the equation; consumers may not understand or interpret correctly the risk information available. While few studies have specifically investigated how people interpret and use warning messages in DTC drug ads, a large body of empirical research exists on how people process information on product warning labels. In a review and synthesis of the work in

this area, Stewart and Martin (1994) note that much of the research to date has been in the form of "surveys to measure either attention to warning, perceived credibility of the messages, or awareness of warning information" (p. 2). These authors note that little research has directly addressed the effects of warnings on decision making, i.e., how individuals interpret and use the information. Several constructs developed from this body of warning label research, however, have direct bearing on DTC drug advertising. For example, Stewart and Martin note that "When warnings serve multiple purposes, the question of effectiveness becomes complex. A warning that is very effective for one purpose may be less effective for another" (p. 2).

As discussed previously, the content of DTC print ads are largely mandated by the FDA to satisfy several levels of legal liability and administrative purposes. The ultimate effectiveness of these messages, therefore, in providing information useful to helping an elderly consumer understand and evaluate the risks and incorporate the information into her interactions with her referent groups may be questioned.

Even skilled medical professionals have difficulty interpreting correctly the actual level of risk contained in a drug's warning label. A study with faculty, staff, and students at Harvard Medical School found that only 1 in 24 participants gave the correct answer when statistical information was expressed in probabilities—"a disease whose prevalence is 1/1000 has a false positive rate of 5 percent"—rather than in natural frequencies (i.e., 15 out of 315) (Hoffrage, Lindsey, Hertwig, & Gigerenzer, 2001). Recently, Pharmacia Pfizer included the following information on the "brief warning" of a Celebrex ad: "Adverse events occurring in ≥2 percent of Celebrex patients from controlled arthritis trials, regardless of causality at recommended doses." Clearly, presentation of risk information in DTC ads may be an area where people of all ages are

still waiting for readily interpretable information. They may be exposed to a risk message, but how do they interpret and use such information?

An experimental study that attempted to determine how the format of the risk information might affect cognitive reactions exposed subjects to mock advertisements for a fictitious influenza drug. The promotional message was held constant in all the ads with the warning formats varying from a general warning disclosure ("all medications have side effects"), to a disclosure simulating the brief summary format found in drug advertisements targeted to health professionals, to a third advertisement that contained the same information as the brief summary but in a narrative format. A fourth control advertisement contained no warning information (Tucker & Smith, 1987). This study found that while the subjects were somewhat reassured by the inclusion of warning information, they were most reassured by ads that contained only the general warning message, rather than by ads containing detailed information on potential risks.

The subjects in the above-cited studies were exposed to fictitious ads outside the context of the medium in which the ads normally would appear. The qualitative framework of this current study allowed participants to evaluate DTC advertising within two contextual levels as the ads normally run in a common publication (the primary context) and in their homes (the extra-textural context of magazine viewing).

Other barriers, such as print size and degree of language difficulty, exist when assessing the potential usefulness of DTC ad content. These issues, however, will be addressed in the section of this chapter that examines the specific information requirements of older adults.

Impact of DTC advertising on patient/physician relationship. In the January 27, 1999, issue of the *Journal of the American Medical Association*, two of the most

polarized viewpoints in the DTC debate were showcased. Alan Holmer, president of the Pharmaceutical Research and Manufacturers of America, debated editorially with Matthew Hollon, M.D., Fellow, Department of Medicine at the University of Washington. Holmer (1999), not surprisingly, claimed that DTC advertising

> is an excellent way to meet the growing demand for medical information, empowering consumers by educating them about health conditions and possible treatments. (p. 380)

While recognizing the rising cost of health care, Holmer claimed that DTC ads actually help reduce the overall costs by informing patients to seek treatment options early, before disease processes are more difficult, and expensive, to treat. This claim has not been fully researched, he admits, and many in the medical community argue that some of the "lifestyle" diseases, for which drugs are heavily advertised, hardly need treatment at all (Dalzell, 1999).

Hollon recognized the success of DTC marketing, reporting the rapid rise in the number of patients who request a drug by brand name, but claimed that, in addition to the increase in costs, DTC leads to "improper use of drugs and harm from adverse events" (Hollon, 1999, p. 382). In addition, Hollon cited several studies that claiming inadequate justification for advertising claims. He also quoted former FDA Commissioner David Kessler's statement that some pharmaceutical companies have distorted information including "data dredging and making claims of 'no difference' from studies with limited statistical power" (Hollon, 1999, p. 383). Hollon concluded by suggesting that the FDA should promulgate stricter regulations, at least until studies show that DTC advertising has public health value and "desirable effects" (p. 383).

It is not surprising that these two JAMA articles elicited a barrage of responses in subsequent JAMA editions. Quotes from two of the letters are interesting for their reflection of some physicians' strong negative concerns about DTC advertising:

> Nor does Holmer discuss the effect on physicians who become involuntary appendages of manufacturers' public relations departments as they field questions inspired by print and television drug ads . . . eroding the close and collaborative relationship that physicians once had with the pharmaceutical industry. (Alper, 1999, p. 1227)

> Direct drug advertising provides no real benefit to patients, is potentially harmful, and is costly. . . . False, misleading, or deceptive drug promotions and advertisements that cannot be supported by clinically valid and statistically reliable data or that contain confusing or misleading words and phrases . . . should be forcefully dealt with and, if necessary, penalties imposed and those responsible prosecuted. (Rosner, Kark, Packer, Bennett, & Berger, 1999, p. 1227)

Although a few physicians report a paternalistic view that "Drugs are too difficult for patients to understand, dosing is hard to understand, and assessment of disease is best done by a doctor" (Newman, 2000, p. 965), most physicians report they are attempting to come to grips with the rapid changes in the health care system. One report claims that 36% of patients who talked with their physicians about a product they saw advertised left the office with a prescription for the medication, and 94 percent of the physicians surveyed agreed to write prescriptions, at least some of the time, for drugs mentioned in patient-physician interactions (Dalzell, 1999).

One of the reasons doctors may acquiesce to patient demands for prescriptions is that they may be afraid of losing the patient (Rosenblatt, 2000). This belief may be justified. In a survey of adults, almost half (46%) reported that they would be disappointed if their physician denied their request for a drug they had seen advertised. Fifteen percent reported that they would consider terminating their relationship with the physician because of a refusal to prescribe a requested drug (Bell et al., 1999).

Managed care has forced time-pressed physicians to see more patients every day. Often physicians find it easier to write a prescription than follow through with a full discussion about a drug (Dalzell, 1999). Nancy Dickey, the AMA's immediate past president, claims that she feels the same pressures in her family practice in College Station, Texas. "I'm not a grocery store, but I must be responsive to my patients" (Dalzell, 1999, p. 30). An interesting and recent analysis of the intended and unintended consequences of DTC advertising (Johnson & Ramaprasad, 2000) noted that however much physicians would like to discuss patients' newly discovered information in regard to possible drug therapies, the realities of managed care often make such discussions impractical. In addition, the authors note that "the informed patient is not the same as an understanding patient. The difference between the two is the informed patient's mere possession of information and the understanding patient's possession of knowledge" (p. 26).

Little is known about how DTC advertising information effects the physician/patient interaction. As discussed above, empirical studies primarily have examined the issue from the physicians' perspective. This qualitative study investigates the impact of DTC advertising information on the patient/physician interaction within the contextual reality of patients' lives.

Perhaps one of the more serious issues in the debate over DTC is the subtle messages that are being sent—that people only have to ask for a pill and that medicines are just another consumer product, like breakfast cereal, laundry detergent, sneakers, and cars. According to the NIHCM (2001) report on prescription drugs and mass media advertising, "The growth of DTC is altering the way prescription drugs are perceived" (p. 7). This altered perception may impact, negatively or positively, how an individual

interprets a drug's relative safety. However, no studies have been found designed to provide a better understanding of how people of any age interpret DTC advertising and incorporate this meaning into their interactions with others.

One health team member whose role is often left out of mass media discussions of the effects of DTC advertising is the pharmacist. The 1952 Durham-Humphrey amendment to the Food, Drug and Cosmetic Act mandated a quite limited role in regard to communication between pharmacists and consumers. This relationship, however, now is recognized as a key component of health care (Davis & Cohen, 1992). In fact, recent federal and state regulations now require pharmacist-patient communication be offered to all patients purchasing prescriptions (Kuserow, 1990). However, real physical barriers—high counters, high noise levels, and lack of privacy—impede even minimum communication conditions in most pharmacies (Schommer, 2000). And although a recent study indicates that while most older Americans say they rely on their physician for information about prescription medications, those with positive attitudes towards DTC advertising were more likely to ask either a friend or a pharmacist, rather than their physician, for drug information (Williams & Hensel, 1995). Few studies, however, have examined the impacts DTC ads have made on the interactions between older consumers and their pharmacists.

Ultimately, like all complex issues, DTC advertising increasingly is being recognized as producing both positive and negative effects. The complex medical, economic, and regulatory issues have created a climate in which many doctors both welcome patients' motivation to be informed about their health care (Dalzell, 1999; Kravitz, 2000) while resenting the time demands and occasional loss of control required

to respond to questions driven by the latest 30-second television ad (Hollon, 1999; Lipsky & Taylor, 1997).

DTC Advertising and Older Adults

Demographic Reality of Aging: A Gendered Society

Virtually all discussions of the health care needs of older people begin with one dramatic demographic fact—individuals older than 65 are the fastest-growing segment of the population, both in total numbers and as a percentage of the population. According to the National Center for Health Statistics (NCHS) (1999), in 1997, 13% of the U.S. population was 65 years of age or older. After 2010, when the first of the large baby-boom cohort reaches this age, the old and the very-old portion of the population will increase dramatically. Current projections indicate that by 2030, almost 70 million people, 20% of the entire U.S. population, will be older than 65 (p. 22). The very old, those older than 85, currently are the fastest-growing segment of the U.S. population, This portion of the population is expected to more than double, increasing from 4.2 million in 2000 to 8.9 million in 2030 (Administration on Aging, 2001).

As the population ages, gender issues become increasingly important. In 2000 there were 117 women for every 100 men in the 65-69 age group; for the population 85 years of age or older, the age differential increases to 245 women for every 100 men (Administration on Aging, 2001). This feminization of the older population means that issues related to older women's health, such as their use of pharmaceutical information, their relationship with their physicians, and the personal and societal cost of their access to pharmaceutical medications, increasingly are important to health care delivery in this

country. The meaning and use of DTC advertising within the lives of older women also has important implications for society at large.

Medical Factors Affecting Older People

While medical advances have contributed to Americans' longevity, most individuals in this "age wave" have one or more chronic conditions (Ham & Sloane, 1992, p. 26). The National Center for Health Statistics defines chronic diseases as those "prolonged illnesses that are rarely cured completely" (1999, p. 40). Some researchers refer to the "three Ms" of aging—"multiple diseases, multiple medications, and multiple physicians" (Hammond, 1995, p. 251). Arthritis, for example, is of one of the chronic diseases that, while not life threatening, can substantially and negatively impact the quality of life and economic health of an older individual. More than half of all people older than 70 suffer from some degree of arthritis, and women (at 63%) have a higher incidence than men (50%) (National Center for Health Statistics, 1999). The remaining most frequently occurring conditions for the elderly are hypertension (36%), hearing impairments (30%), heart disease (27%), cataracts (17%), orthopedic problems (18%), sinusitis (12 %), and diabetes (10%) (Administration on Aging, 2000).

Multiple chronic diseases mean that many older people are taking many different medications. One study estimates that the 12.7% of the U.S. population older than age 65 are taking 35% of all prescription drugs (Anderson & Wahler, 2001). While not all seniors have equal access to medications, those who do participate in commercial health plans used an average of 29 prescriptions per year, more than four times the average seven prescriptions per year for younger people (Drug Benefit Trends, 2000).

Multiple prescriptions mean that patients are at higher risk for complications from drug interactions, or adverse drug events (ADE). As older people develop multiple chronic disorders, the likelihood of ADE increases. Not only do older people take more prescription drugs, they also take more over-the-counter drugs, increasing the possibility of drug interactions (Anderson & Wahler, 2001). And older people are at even greater risk because many ADE can cause confusion or impaired function that can be mistakenly diagnosed as depression or one of the dementias of aging. When such reactions occur, additional drugs are needed to treat the apparent symptoms, producing additional costs and risks.

Economic, and Political Context of DTC Advertising Targeted to the Elderly

In spite of the health risks associated with polypharmacy, or multiple prescriptions, among the elderly population, the debate about the effects of DTC on older people has focused more on the economic costs associated with providing more and increasingly expensive drugs to a rapidly growing segment of the population. Barrett Toan, chief executive office of a pharmacy benefit management firm has argued

> Because seniors depend so heavily on prescription drugs, bear some of the highest costs, and have such complex utilization patterns, providing them with prescription drug coverage is one of the biggest challenges on the pharmacy landscape . . . there should be a prescription benefit for seniors, either through Medicare or some other initiative, but it should be understandable and easy to administer, and it should encourage cost-effective behavior by the beneficiary. (Drug Benefit Trends, 2000, p. 7)

As discussed in Chapter 1, the costs of prescription drugs are rising yearly—up a record 17.1%, $131.9 billion to $154.5 billion, from 2000 and 2001 (NIHCM, 2002, p. 5). Some health professionals believe that DTC drug advertising is encouraging Americans, especially those enrolled in managed care plans, to see prescription drugs as just another benefit that is their due. For example, Nancy Dickey, the previously cited

former AMA president and rural family physician, says that in discussions with her patients "I talk about costs. This concept, 'It's free'—well, it ain't free, buddy. But there's only so much social education I can do in 15 minutes" (Dalzell, 1999, p.31). Other physicians lay the blame directly on the door of pharmaceutical ads. In a recent CBS news piece entitled "Patients driving higher drug costs," Dr. Raymond Woosley of Georgetown University Hospital was quoted as saying, "People are bombarded by advertisements which tell them the glowing attributes of all these new medicines. They come to you . . . and say, 'I want this medicine'" (CBS News, 2000).

According to economists at the Congressional Budget Office (CBO), if Medicare's present benefits stand, Medicare costs are projected to rise from the present 2.3% of the gross domestic product to 4.4% by 2030 (Samuelson, 2000). If current trends on prescription drug expenditures continue, prescription drug costs will increase from the current 10% of national health costs to 15% by 2011 (NIHCM, 2002, p. 3). The issue of prescription drug benefits for Medicare recipients was a driving force during the Bush-Gore 2000 presidential debates. After the 2000 election, President Bush recommended a $190 billion package to help elderly Americans purchase prescription drugs; some Senate and House Democrats propose prescription assistance packages that could cost more than $700 billion (Goldstein, 2002). The economic implications of these figures are impressive, especially in relation to seniors' access to, and demand for, prescription drugs. The Administration on Aging reports that in 1998 Medicare beneficiaries age 65 and older annually spent an average 12 % of their income ($2,936 per person) on health care. A large percentage of this expense was for prescription drugs which currently are not covered by Medicare. According to this report, older Americans spent 22% ($620) of their total health costs on drugs.) (Administration on Aging, 2001). Currently, one-third

of the 40 million disabled and elderly (older than age 65) Americans lack prescription drug coverage (Carter, 2002). Clearly, economic issues may be an important part of the contextual reality within which an elderly person interprets DTC advertising.

Managed care companies have attempted to curtail the rising drug costs, especially of the newer, more expensive, and more heavily advertised drugs, through a variety of means. Some have required enrollees to meet strict medical criteria to qualify for coverage; others have demanded that members try cheaper medicines first; still others simply refuse to cover some of the drugs like Celebrex and Vioxx that have less expensive treatment options available (Associated Press, 2000). At the extreme end of the cost-cutting spectrum, at least two managed care firms have required patients to get half their prescriptions in double the dosage form. Because drug costs were the same regardless of dosage level, patients have been ordered to split the pills and take half a pill at a time (McCarthy, 1999a). At the national level several attempts or proposals to lower drug costs for older Americans were initiated in early 2002. These included drug discount cards for low-income elderly begun by several pharmaceutical companies, a national chain drug store association proposal to consolidate drug company discounts into one card, and a Bush administration proposal for a drug card for low-income elderly Americans (NIHCM, 2002, p. 3).

Some state and national legislators are considering other means to stop the rising costs of drugs. At the state level, several northeast states are pursuing price controls to curtail rising costs (Pear, 2001 a); some members of Congress are proposing a bill that would bring greater FDA oversight of DTC drug advertising. According to *Advertising Age*, legislators have confirmed that rather than directly imposing any rules on DTC ad content, increased funding might be proposed to increase FDA staff to review DTC ads

as well as establish a governmental advisory panel to develop ad standards (Goetezl & Tenowitz, 2001, p. 3). Clearly, DTC pharmaceutical advertising has made an impact on the national consciousness. What has been learned of how elderly people evaluate the effect of DTC advertising on their self-image, on their relationships with members of their referent groups, and on their role as a patient?

Social Realities of Aging

The aging process affects older women differently than older men both at the intrapersonal and interpersonal levels. An older woman is perceived differently than an older man by family, friends, health care providers, and—perhaps most importantly—herself. The following section will examine these realities for issues that may affect how an older woman may interpret and use DTC advertising information.

Self-images of aging: A woman's perspective. There is a noteworthy lack of nonproprietary research—either quantitative or qualitative—on the effect of DTC advertising on women's sense of self. In *The Fountain of Age* (1993), a former best-seller on women's aging, the feminist author Betty Friedan noted

- In *Vogue*, of 290 identifiable faces in ads, there was only one of a woman who might have been over sixty—in a tiny snapshot of "me and granny."
- Of the 116 identifiable faces in the *Vanity Fair* illustrations, there were two women clearly over sixty—the Queen Mother and Imelda Marcos—and ten older men, all powerful or famous.
- In the *Ladies Home Journal*, of 72 faces in ads, two might have been in their sixties—old style grandparents in a candy ad. (Friedan, 1993, pp. 38-38)

According to Cooley (1902/1964), the essential empirical self begins with self-feeling--the body (Holstein & Gubrium, 2000). The importance of an individual's self-image to his or her self-awareness throughout life cannot be underestimated. Cooley's well-known analogy of the "looking glass self" actually has three components: "The

imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling, such as pride or mortification" (p. 184).

In American society, especially among the present cohorts of elderly women, a satisfactory sense of "self" may disproportionately depend on maintaining an unrealistically youthful appearance. One study of women and aging quotes a respondent:

> I used to look in the mirror and see myself . . . now I see my mother. I feel as if I look out at the world from behind my face. My face feels the same, but when I look in the mirror, it's an older woman who stares back at me. I always liked the way I looked and sought out mirrors for the pleasure of looking at myself. Now I hate mirrors. I feel better when I just feel and don't look. (Pearlman, 1993, p. 6)

Potential effects of DTC advertising targeted to older women was noted in a recent analysis (Tudiver, 2001). This author suggested that DTC advertising, for this population group, has more negative than positive potential. For example, she suggested that the content of DTC ads often "plays on women's fears, contains questions designed to heighten worries, and distorts consumer choice and women's empowerment"(p. 2).

An example of ad copy that plays on women's fears is found in an ad for Datrol LA, a drug to treat problems of urinary incontinence sometimes experienced by older women. The copy includes the questions "Going frequently? Sudden urges to go? Afraid you won't make it in time?" The ad continues with a self-diagnostic "test" for readers, followed by the admonition, "If you answered 'yes' to even one of these questions, bring it to your doctor and ask about once-daily Detrol LA." It also should be noted that the female model appearing in this ad's art appears to be considerably younger than age 60 and well outside the age parameters of women most likely to experience problems with urinary incontinence. Although this drug is developed for a condition most often found among older women, the use of relatively young models may carry an implied message

that women should start worrying as early as middle age about the possibility of developing urinary incontinence.

Referent groups and health. Referent groups have long been known to be an important component to the health and well-being of older adults.

> Reference-group theory appears particularly fruitful as a means of explaining the seeming disparity between the deprived life conditions of older persons and their retention of good morale . . . reference groups can perform two functions: they can provide the actor with a set of values and norms (the normative function), or provide a point of reference with which he can compare his life situations (the comparative function). (Bultena & Powers, 1976, p. 165)

Older people, especially older women, are more likely to live and interact most often with persons of similar age and gender. A 1968 study (Bultena,1968) found that older people interacted primarily with age mates and that most intergenerational contacts were with family members. Because women increasingly outnumber men as they age (Administration on Aging, 2001) and old women are more likely to live alone than old men (Davis, Moritz, Neuhaus, & Barclay, 1996), it may be assumed that the referent groups of many older women are made up of other women of a similar age.

The feminization of older women's referent groups may have both positive and negative implications. For example, some studies indicate that young adults tend to rate physically attractive older women as less attractive than they rate younger women of comparable beauty (Burns, 1978), while judging older males less harshly (Puckett, Petty, Cacioppo, & Fischer, 1983). If true, then interaction with others of similar age might be assumed to be of positive benefit. However, there also is some indication that older people tend to view middle-aged individuals in a more favorable fashion than they do individuals of their own cohort (Adams & Huston, 1975). In relationships that are important to life satisfaction, however, elderly people have shown a preference for middle-aged and older individuals (Goebel, 1982).

Several studies have noted the importance of friendships in the personal lives of older women (Roberto, 1996). One study of the interactions of women 65 and older and their close friends surveyed 94 women and found that, while the women reported disclosing a wide variety of information on a range of topics, this cohort of women, socialized in an era that valued privacy more than openness, reported a hesitancy in discussing intimate topics (p. 69). How do these groups process and manage health care information, especially information gleaned from DTC advertising?

While no studies have been found that specifically examined how older women managed health care information in informal, interpersonal networks, an insightful qualitative study used an ethnographic approach to study how younger women discussed their own, their family members,' and their friends' health experiences and issues (Tardy & Hale, 1998). Using participant observation, these researchers studied the conversations of approximately 30 mothers participating in a mothers' and toddlers' playgroup. The health-related conversations of these mostly younger women (age 23 to 43) were focused on "cracking the code of institutional practices" as well as "a bonding function evidenced through stories or narratives" (p. 151). This qualitative inquiry, using observation and interview methodologies, may shed light on the differences between women of these younger cohorts and older women in discussing health-related topics.

Interpersonal issues in older patient/physician interactions. The empirical literature on the nature of the communication between patients and health care providers—almost exclusively physicians—is extensive (Haug & Ory, 1987). Of this wealth of studies, a significant number have focused on the communication exchange between physicians and their older patients (Haug, 1996). Only the more recent studies, however, have begun to examine more closely the specific doctor and patient

characteristics that affect this interaction. Some of these characteristics are demographic—the age, gender, ethnicity, class, and religion of both the physician and the older patient (Haug, 1996).

The old are not a monolithic group. They do not even comprise a single cohort. The "elderly" range in age from the young-old (65 to 74 years), the old (75 to 84 years), and the fast-growing group of old-old (those 85 and older). Their life experiences range from memories of World War I and the great flu epidemic of 1919 to growing up in the Depression and enlisting in the services in World War II. Even before such issues as degree of education and health levels are factored in, each new office visit of an older patient presents a physician with a wide range of patient profiles. It is much more difficult for a physician to consider an "average" 80-year-old than to discuss an "average" 2-year old.

Physicians themselves, of course, also respond variably to older patients. Few studies, for example, have examined whether older physicians have more rapport with older patients. There is evidence, however, that some younger doctors may be less patient and less respectful than some of their older colleagues (Adelman, Greene, Charon, & Friedman, 1990). For example, younger doctors may be more likely to be addicted to *first name syndrome* (Haug, 1996, p 250), the tendency for the doctor, regardless of age, to address an older patient by his or her first name. While the doctor is almost always addressed by the professional title, some doctors still fail to remember that 80-year-old "Mary" sitting on his exam table in a paper robe is a well-published Ph.D. who retired 10 years ago from a long academic career.

Other communication problems found in the medical encounter with older people may include speaking loudly and/or more slowly or using a simplified language. In

addition, doctors may take on a patronizing air or blame older patients for "forgetfulness" for a noncompliance error that in a younger patient might be excused as "business" (Ryan & Cole, 1990). Women physicians, however, have been found to be more egalitarian in interacting with their patients, spending more time in talking with them and providing more information and support (Roter, Lipkin, & Korsgaad, 1991). Finally, different physicians have different "practice styles." Some see themselves as agents for their patients (Eisenberg, 1985), while others focus on decision-making based on mathematical models or computer-generated decision trees (Doubilet & McNeil, 1985).

In the past, the class relationship of a physician and an older patient almost always has been characterized as asymmetrical; with only the wealthiest patients having the status and income of the physician (Haug, 1996). However, an increasingly consumer approach to health care, combined with a growing managed care environment where physicians frequently function more as an employee than an independent professional (Halter, 1999), has caused more patients of all ages to view the physician as a "service-provider" than as an independent professional (Wiemann, Gravell, & Wiemann, 1990).

Another factor that is having an increasingly important impact on the physician-patient relationship, especially doctors' interactions with older patients, is the length of the relationship. How long have the physician and the patient known each other? In the past, people grew old along with their doctors, only reluctantly changing physicians when the doctor finally retired or died. Today, major changes in the managed care system, combined with the migration of many retirees to retirement communities in different areas of the country, mean that an older patient may be no more likely than a younger person to have a long-established relationship with a physician.

As noted previously in this chapter, older people frequently suffer from multiple chronic conditions (Ham & Sloane, 1992; Halter, 1999). Some of these chronic conditions, like hearing difficulties, vision loss, lack of mobility, and impaired cognition, can themselves impede communication in physician-patient interactions (Haug & Ory, 1987). In addition, treatment options are increasingly diverse and complex. Jon Halter of the University of Michigan Geriatrics Center says

> the complementary nature of treatments available make multiple drug regimens for a given condition both intellectually appealing and frequently recommended . . . for conditions such as osteoporosis, hypertension, coronary artery disease, congestive heart failure, chronic obstructive lung disease, and diabetes mellitus. Although multiple drug regimens may be attractive, they present a clear challenge . . . even for the patient who has only one of these health problems. But what about the patient who has many or even all of them: The complexity of the overall treatment program can become overwhelming. (Halter, 1999, p. 25)

The physician, when confronted by an older patient with complex medical comorbidities who has come in solely to get a prescription, is confronted by a treatment and scheduling dilemma. How, in the context of a standard 15-minute office visit, can a physician reasonably provide information covering multiple chronic conditions and providing "explicit directions concerning medication and other therapies, along with a clear rationale and explanation of the purpose of the regimen" (Haug & Ory, 1987, p. 23) recommended by best medical practices?

The issue of failure to follow treatment recommendations, or "noncompliance," has generated a large body of medical literature. The problem has been identified as "the most significant problem facing medical practice today" (Eraker, Kirscht, & Becker, 1984, p. 258). As many as 50% of individuals with chronic conditions fail to follow treatment programs, and as many as 92% are noncompliant with short-term medicine recommendations. The more prescriptions prescribed, the more likely a patient will not

follow directions (Becker, 1985). And, as discussed, the more prescriptions an elderly patient takes, the more likely he or she may be to have an adverse drug event. For the elderly, the use of prescription medications can have serious health consequences.

The previous sections of this chapter discussed DTC advertising within the social contexts of older individuals' lives. The following sections of this chapter examines three textual elements of DTC advertising—type size and layout, language complexity, and presentation of risk information—that may affect how older people interpret and use DTC advertising information.

Elements of Print DTC Pharmaceutical Advertising

As discussed previously, print media have the FDA-mandated responsibility for disclosing key pharmaceutical information such as usage, contraindications, warnings, precautions, and adverse reactions. Television advertising merely is required to refer the audience to another source—a 1-800 telephone number, web site, physician, or magazine ad—for this important information (Ohliger, 1999). For older individuals, the selection of print media as the primary source for drug information may be problematic. The most common sensory problem faced by the elderly is vision impairment (Ham & Sloane, 1992). One national health survey revealed that almost 95% of those older than age 65 reported either wearing glasses or needing glasses or some other form of corrective lenses. Of those older than age 85, 55% report visual problems even with corrective lenses (Kovar, 1984). According to one geriatric handbook, the impairment in refraction capability of the older eye is "almost universal." Other common conditions contributing to the decreasing eyesight so common in aging are glaucoma, cataracts, macular degeneration, and diabetes (Ham & Sloane, 1992).

Copy Size and Layout

In a meta-analysis of studies focused on legibility of type design in medical material designed for older readers, Hartley (1999) identifies page size, line length, typefaces, type size, and use of space as key components affecting whether print material is easy to read and understand for this audience segment. While Hartley reported significant variation among the types of studies and in the definition of old age, he identified a consensus from five studies for a type size of 12- to 14-points, with 12-point type as a minimum for legibility.

Table 2-1. Guidelines for textual designs

Type characteristic	Guideline
Column widths	Avoid a single column of text on a large page. One narrow and one wider column may be easier to read and allow for larger illustrations. Unjustified text, in shorter line lengths, is also more legible for older readers.
Type faces	Use conventional rather than exotic type faces and avoid use of more than two typefaces in one document.
Spacing	Create spacial cues by providing space around important points. Provide typographical spacing cues such as bullets to assist reader in organizing and retaining information. Other spacial cues include proportional systems such as one space between paragraphs; two spaces above and one space below a secondary heading.
Cueing headings	Use typographic cues such as capital letters for main headings, upper and lower case bold for secondary headings, etc. Avoid use of all capital letters for emphasis. Use bold or italic, but not both together. Avoid multiple cueing systems.
Color	Black print on white paper has the best contrast value. Legibility is impaired when dark text is printed on strongly colored back-ground or when text is printed over differently colored illustrations and/or black-and-white artwork.

Source: Adapted from Hartley, 1999, pp. 235-236

The organization of type—the design elements involving spacing and placement on the page—can almost be as important as type size for all readers. This is especially true for older audiences. The length of the line and the spacing between words, lines, and paragraphs assist readers in comprehending and retaining information. For example, Hartley's (1999) analysis of several studies identified the use of unjustified text, especially when the line length was short, as the second most useful element in improving legibility for older adults. The following table is adapted from Hartley and provides guidelines for textual design decisions for medical information for older readers.

Language and Comprehension

As important as type size and placement may be in allowing a reader physically to access information, the language of the text ultimately determines the information available to a reader. As discussed previously, one justification for DTC pharmaceutical ads has been grounded in their purported usefulness in providing critical health information and for cueing important patient-physician conversations (Holmer, 1999). In a key content analysis of DTC prescription drug magazine advertisements, however, Bell, Wilkes, and Kravitz (2000) found that only 60% of the ads mentioned the symptoms associated with the condition for which the drug was developed; less than 25% mentioned any supportive behaviors (diet, exercise) that would aid in treatment or reduce complication risks; and less than 10% provided information related to the success rate of the advertised drug. These authors go on to state that "the large majority (of the DTC ads) do not inform potential patients about such basic matters as the risk factors for the condition or its prevalence" (p. 1096). On the other hand, the required "brief summary"

that is often attached as a second page to DTC magazine ads is filled with scientific terminology mandated by the FDA and set in dense, small type.

Few studies have examined the most effective language usage for DTC print magazine ads, and none has been found that addresses the development of guidelines for language that would enhance understanding of these ads by older readers. This section will first identify the language style elements shown to be useful in presenting complex medical information for readers. It will then address the more complex issue of understanding of medical information by older readers.

Hartley (1999) addressed the optimal language structure, as well as the type and design elements, identified in previous studies to enhance older readers' understanding of print messages containing medical information. While much of this existing literature has focused on designing medication instructions for older adults (Morrow & Leirer, 1999), the constructs also should be relevant for message design for DTC drug ads targeted to older consumers. These language elements include

- Concepts and words that readers understand.
- Deleting unnecessary words.
- Active rather than passive voice.
- Introductory, interim and concluding summaries.
- Main and secondary headings to convey structure.
- Relatively short paragraphs.
- Avoiding sentences containing two or more subordinate clauses. (Hartley, 1999, p. 234)

It is interesting to note that none of the previously discussed studies describing DTC advertising copy provide any analysis of the imagery used in the advertising art.

While studies were found that examined DTC advertising ad copy, including the small print in the FDA-required "brief summary," no studies were located that attempted to examine the pictorial content of these ads. As discussed previously, many of the ads for the top-selling drugs are to promote products designed to relieve the high cholesterol and arthritis of aging (NIHCM, 2002), yet no studies have determined whether these ads use models that are of an age comparable to the target market.

Cognitive factors are of another area of concern when designing messages for older adults. Zwahr (1999) lists four discrete cognitive abilities important to medical decision-making: memory, comprehension, reasoning ability, and working memory (p. 63). While many adults have no decrease in cognitive ability, a significant number experience age-related declines in areas of cognition such as working memory capacity and speed of information processing (Salthouse, 1991).

Socio-economic issues, such as level of education, also may play a role in determining an older person's ability to comprehend a DTC drug message. Although focused on a general population and not specifically on the elderly, one study that did examine the impact of DTC advertising on drug knowledge and drug-requesting behavior found no association between age and prescription drug knowledge or requests (Peyrot et al., 1998). A positive association was found, however, between increased drug knowledge and the belief that drug advertising could be educational. In other words, this study suggests that more highly educated people are more likely to believe in the educational value of DTC advertising. The use of such beliefs in the interactions of individuals with referent group members or physicians, however, is not explored.

In a review of three empirical studies, Park, Willis, Morrow, Diehl, and Gaines (1994) found that adherence to a medication protocol depends on beliefs about the value

of treatment as well as on well-designed instructions. This review of cognitive function and medication usage in older adults evaluated studies from three different cognitive aging laboratories. They found that cognitive function, clear and explicit instructions, and belief systems all were critical to older patients' medication usage. While cognitive function is an important construct in any study of the aging and comprehension, the evidence on "selective nonadherence," or taking one medication correctly but not another, should be noted. The authors suggest that "some nonadherence may relate to beliefs about drugs rather than cognitive abilities" (p. 55). In other words, an older person may have knowledge about a drug, but may interpret its usefulness differently than in the manner prescribed by the physician. It may be hypothesized, the authors further suggest, that adherence to the recommended schedule for drugs for a very painful chronic condition, such as arthritis, might be different than adherence to the drug schedule for a "silent" but life-threatening condition such as hypertension or diabetes. These findings, it must be noted, concern older individuals' comprehension of medication treatment protocols, not the issue of DTC pharmaceutical advertising and intention to request the advertised drug.

A study providing more direct insight into older people's reactions to DTC pharmaceutical ads was conducted by Williams and Hensel (1995). This survey of 190 older (>59) adults living independently showed that those with positive attitudes toward DTC advertising expressed greater intention to seek additional information from a physician, pharmacist, or friend about the advertised prescription medication. This relationship between a belief in the efficacy of drug treatment and request for more information also was suggested in a large survey of a general population (Peyrot et al.,

1998) which found that people who preferred brand name drugs were more likely to request them.

One study (Christensen, Ascione, & Bagozzi, 1997) used the Elaboration Likelihood Model to examine how elderly patients process drug information contained in DTC advertising. This experimental study, which used three measurement scales (involvement, argument quality, and source credibility), confirmed that situational differences, such as differing levels of involvement, may determine whether older individuals pay close attention to information presented in a DTC drug ad.

Two studies (Christensen, Ascione, & Bagozzi, 1997; Williams & Hensel 1995) that specifically addressed DTC advertising information processing by elderly patients, suggest that strength of belief about a drug's potential efficacy may be a useful construct in gaining a greater understanding of the factors underlying an older audience's reaction to DTC drug ads. In other words, if older people believe that a drug may help them, will they then pay greater attention to DTC advertisements for that drug?

The studies discussed above suggest that an elderly individual's understanding of the efficacy of a drug may contribute to drug requesting behaviors as well as to "compliance," or adherence to medication schedules. However, there also is an implication in these studies that sometimes, under certain conditions, older people may comprehend but choose not to comply with a medical protocol. This current study asks some elderly women to reveal, in their words, their perceptions related to obtaining and taking prescription medications.

Risk Information

At the most essential level, *risk* can be defined as "the possibility of loss" (Yates & Stone, 1992). Communication conveying the degree of potential loss is a *risk*

message, a "written, audio, or visual package developed with the express purpose of presenting information about risk" (National Research Council, 1989, p. 322). The body of research investigating the impact of risk warnings is extensive. Since the passage of the Pure Food and Drug Act of 1906, much of this literature has focused on warning labels attached to a wide variety of products (Hadden, 1991). These labels are required by regulatory statutes to provide information concerning the relative risks associated with the product. Information provision is the most favored method of consumer protection in the United States because it allows more choice in the market place and it is more economical to regulate (p. 93); it also places the responsibility for safety more squarely on the shoulders of the consumer.

The effectiveness of information provision is dependent on two assumptions: first, that consumers can read and understand the message, and second, that they will act on this understanding. A plethora of research studies on warning messages on products ranging from food products to toys to hazardous cleaning materials suggest that the effectiveness of these warning messages is moderate at best; people often ignore risk messages. In fact, the very presence of the message may produce a false sense of safety. One study in Sweden, for example, revealed that consumers believe the labeling itself provides a safety certification (Thorelli & Thorelli, 1974).

In August 1999 the FDA provided pharmaceutical manufacturers with "final guidance" published in the Federal Register for provision of product warning labels. According to these regulations, broadcast advertisements for pharmaceutical products must disclose the product's major risks in either the audio alone or in both audio and visual elements of the ad (Ohliger, 1999). The regulation went on to require that the ad either contain a brief summary of these risks or provide "adequate provision" for

dissemination of the information through a 1-800 telephone number, referral to a health care provider, to an Internet website, or to a concurrently running print advertisement (Ohliger, 1999). These regulations, however, do not specify the form or language of the warning, giving advertisers considerable discretion in message development. While advertising agencies have used a variety of print formats in an attempt to comply with these restrictions, they are under no regulatory requirement to report all of the side effects or even all of the major side effects. Few print advertisements have incorporated the elements that research has shown to be most useful in communicating risk information. The following discussion summarizes these elements.

In the previously discussed review of product warning label studies, Hadden (1991) notes that, in spite of the importance of appropriate language, no systematic or comprehensive efforts have ensured that consumer warnings are explained in nontechnical, easily understood language. In fact, Hadden questions whether many warnings can use effectively simple, understandable language, claiming that graphic icons (such as the circle crossed by a diagonal slash) may be more useful and appropriate, especially for less complex risk messages. For many pharmaceutical products, however, the degree of risk, including the likelihood and severity of side effects and the potential for adverse interactions with other drugs and substances, creates a complex message that cannot easily be conveyed by symbols or icons.

Two recent paired studies conducted by Davis (2000) were designed to explore the relationship between the statement of risk describing drug-associated side effects' and consumers' perceptions of the drug's safety and appeal. The findings are particularly relevant for this study because, in the first phase of the study, the use of the imprecise frequency descriptors ("some," "many," and "few") often found in actual drug ads

appeared to increase respondents' assumptions that the risks of side effects were low. This portion of the study also found that reassuring copy, such as "Though most users experience trouble-free relief" (p. 360) also might lead to the high level of consumer confidence in prescription drugs reported by Bell, Wilkes, and Kravitz (1999). The second phase of this study used comparisons between minimal levels of reported side effects and the use of numeric risk information. While the study population was small (n = 58), the authors report that respondents were significantly more likely to recommend or purchase a drug described with an incomplete risk statement. These findings are compatible with the previously discussed study (Christensen et al., 1997), which found that subjects favored the product more when the ad contained low risk arguments.

Other studies confirm that "some individuals cannot bear to think that bad things may happen to them and, having a natural desire to escape any further unpleasantness, may avoid information" (Pierce, 1996, p. 284). However, information, especially quantifiable statistical information, is essential to making useful medical decisions. Statistics can be expressed as probabilities (a one in four chance), percentages (25%), or absolute frequencies (25 out of 100). While there is no mathematical difference between these concepts, one recent study (Hoffrage et al., 2001) indicates that there is a significant psychological advantage in presenting statistical information as an absolute frequency. In a survey of physicians, the researchers found that only 1 out of 24 gave the correct answer when the statistical information was expressed in probabilities. When the same information was given in natural frequencies, 16 out of 24 physicians gave the correct answer. Clearly, if utilization of natural frequencies can assist physicians in understanding quantitative information, it certainly should facilitate consumers'

understanding of the degree of risk associated with potential side effects for an advertised drug.

To summarize, several recent empirical studies have revealed language structures that have been shown to convey risk information in a more readily understandable format. These concepts are

- Provide numeric information, rather than vague wordings of "some," "many," and "few."
- Avoid the use of copy cues that create the assumption of low risk—"and while most people tolerate Xefren well."
- Report all side effects that have a greater than 3 percent base level of incidence.
- Express statistical information as natural frequencies rather than probabilities or percentages. (Davis, 2000; Hoffrage et al., 2001)

If incorporated into DTC pharmaceutical advertising copy along with comprehension language elements, these concepts should increase understanding of DTC advertising by elderly individuals.

The theoretical and historical foundations developed from the review of previous research provide a basis for this qualitative investigation into how elderly adults interpret DTC pharmaceutical advertising and create understanding from this information. In addition, this inquiry investigates how the social context—the referent groups—of older people, influence and are influenced by their exposure to DTC advertising. From this foundation, an hypothesis and a number of research questions are proposed for testing as described in Chapter 3.

Research Questions and Hypotheses

Based on the literature discussed in this chapter, the following research questions and hypothesis have emerged:

H1: Elderly people will have diverse interpretations of DTC pharmaceutical advertising because they have variable experiences and socialization related to health-related behavior.

R1: What do DTC pharmaceutical ads mean to elderly people?

R2: How do elderly women use referent group norms in their evaluation of DTC advertising?

R3: How do elderly women use DTC advertising as an information source when discussing health-related topics in their referent group interactions?

R4: How do elderly women incorporate DTC ad information in their interactions with their primary care physician?

R5: If elderly women feel these ads call for a change in their interactions with their physicians, how do they feel these ads affect such a change?

R6: How do elderly women feel about requesting a prescription for a drug for a stigmatized condition?

R7: How do elderly women expect their physician to respond to a request for a DTC advertised drug?

R8: How do elderly women evaluate the usefulness of DTC advertising?

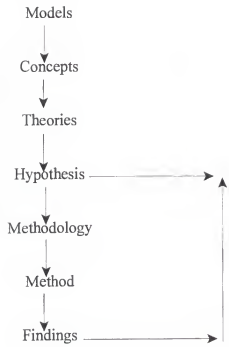
CHAPTER 3
METHODS

Introduction

The following chapter is a discussion of the research methodologies, assumptions, and procedures selected for this qualitative study. The quotation at the beginning of this chapter reflects a highly relevant question raised by an elderly respondent during a preliminary inquiry for this study. As discussed in Chapter 2, much DTC advertising is for drugs for the chronic conditions besetting elderly people (Bell, Kravitz, & Wilkes, 2000; Rosenberg, 2000), yet most of the present cohorts of individuals older than 65 were socialized during eras in which physicians were perceived as authority figures (Beisecker & Thompson, 1995; Haug & Ory, 1987). How does an older person interpret a command to "ask your physician" for this medication?

This inquiry into how a group of elderly women interpret and use DTC advertising in their construction of a sense of health and in their interactions with referent group members and their physicians is particularly appropriate for a theoretical and methodological inquiry grounded in the acceptance of multiple constructions of reality. The following section defines the integration of the methodological strategies used in this study with the theoretical structure on which this study is based.

Qualitative analysis includes multiple levels of models, theories, and methods. Silverman schematically illustrates seven levels of analysis illustrated in Figure 3-1.



(Source: Silverman, 2000, p. 79)

Figure 3-1. Levels of Analysis

According to Silverman (2000), a model or theory is an overall framework for looking at reality. This study seeks a richer, deeper understanding of the multiple realities of a group of people, each of whom has a cumulative personal history and multiple life experiences. According to Lincoln and Guba, a constructivist understanding of knowledge accepts that reality is based on individual reconstructions "coalescing around consensus" (2000, p. 166).

Manis and Meltzer (1972) describe the symbolic interactionist model as a social psychological theory with a strongly embedded ethnographic methodological tradition. As discussed in Chapter 2, symbolic interactionism, the study of how the self and the social environment mutually define and shape each other through symbolic

communication (Lindlof, 1995), is one of a number of theoretical perspectives included within the constructivist paradigm (Denzin & Lincoln, 2000). These theories assume

> a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent cocreate understandings), and a naturalistic (in the natural world) set of methodological procedures. (Denzin & Lincoln, 2000, p. 21)

This inquiry attempts to understand how elderly people construct meanings for the symbolic language and images of DTC pharmaceutical advertising and then use these meanings in interactions with friends, family, and physicians. The importance of the individual construction of reality, inherent in symbolic interactionism, is particularly appropriate when attempting to understand how elderly people construct their role as a patient:

> Symbolic interactionists, especially those working with a dramaturgical or strategic interaction vocabulary, highlight those performative hows, bringing into view the myriad techniques for managing roles and relationships. (Gubrium & Holstein, 1997, pp. 215-216)

Before discussing methodological approaches, it may be useful to examine briefly the ontological and epistemological implications of viewing symbolic interactionism within the broader constructivist paradigm. Denzin and Lincoln (2000) identify in tabular form the basic beliefs and paradigm positions of five paradigms (positivism, postpositivism, critical theory, constructivism, and participatory). In tabulating the paradigm positions on selected issues, these authors assert that only constructivism ontologically explicates "local and specific constructed realities" (p. 165). The authors note that the constructivist paradigm differs from positivist and postpositivist models across a variety of ontological, epistemological, and methodological issues. For example, constructivists (a) posit that the nature of knowledge is based on "individual reconstructions coalescing around consensus;" (b) share control between inquirer and

participants; (c) and base goodness or quality on "trustworthiness and authenticity" rather than on the positivist benchmarks of internal and external validity, reliability, and objectivity." (p. 170). In short, constructivists . . . tend toward the antifoundational (Lincoln, 1995, 1998; Schwandt, 1996). Antifoundational in this sense denotes a refusal to accept that there is a permanent, unvarying "foundational" standard by which truth can be universally known. Truth within the qualitative framework arises as a consensus mutually developed among members of some stake-holding community (Lincoln, 1995). The basic ontological premises of symbolic interactionism, a constructivist theory, therefore requires methodological approaches that are qualitative, not quantitative.

In qualitative inquiry, truth is developed among study participants and researchers within the context of the inquiry encounter. Silverman (2000) suggests that "participants in social life actively produce a context for what they do and that social researchers should not simply import their own assumptions about what context is relevant in any situation"(p. 66). Symbolic interactionism, as we have seen, poses a reality that is socially constructed by individuals from their individual contextual interpretations. Qualitative methodologies—inductively grounded, with multiple contexts, in natural settings, and exploratory, holistic, and process-oriented—are most appropriate for this inquiry into elderly individuals' creation of social realities surrounding the interpretations and implementation of DTC advertising information.

Quality Evaluation Within the Qualitative Paradigm

Qualitative researchers recently have enjoyed a new-found "truce" in their defense against those social scientists who have felt that only by adopting a positivist, empiricist approach to social inquiry could valid research be accomplished (Denzin & Lincoln, 2000; Lindlof, 1995;). Denzin and Lincoln, while recognizing that qualitative

research has had a "sometimes anguished" history (p. 1), claim that qualitative research now has achieved a legitimate claim in the social sciences. These same authors claim that, in spite of the current practice of extensive interweaving of various theories and models, in the long run studies based on a qualitative paradigm simply are not commensurate or accommodative of positivist or postpositivist positions (pp. 163-177). However, studies that are grounded in critical, constructivist, or participatory positions may integrate a combination of paradigms. For example, a symbolic interactionist study might include a feminist viewpoint. In communication studies, Lindlof (1995) recognizes that

> Communication research now accommodates many different styles of inquiry, living side by side, (with) the methodologies that support the program of objectivist science—especially the use of variable-analytic designs and probability statistics—no longer (constituting) the only means for doing credible research. (p. 7)

Studies based on symbolic interactionist theory reject positivist or empirical measures of quality: *internal validity* (the degree to which findings correctly map the phenomenon); *external validity* (the degree to which findings can be generalized to another setting); *reliability* (the extent to which findings can be replicated by others); and *objectivity*, (the degree to which findings are free from bias) (Silverman, 2000, p. 91). These benchmarks are replaced by the concepts of *trustworthiness* and *authenticity* as the measure of the goodness or quality of qualitative research (Denzin & Lincoln, 2000).

Trustworthiness

The growing credibility of qualitative studies is due to the application of new criteria specifically developed for the evaluation of goodness. Lincoln and Guba (2000) identify, compare, and discuss four of these evaluative qualities. The traditional and somewhat comparable measures of objectivist inquiry are included in parentheses:

credibility (internal validity), *transferability* (external validity), *reliability* (dependability), and *confirmability* (objectivity) (Denzin & Lincoln, 2000, p. 21). In the context of qualitative research, Denzin and Lincoln (1994) suggest that "trustworthiness" is a more appropriate term than validity because it "signifies a different set of assumptions about research purposes" (p. 151).

Although qualitative researchers reject the concept of objectivity, Lincoln and Guba (2000) suggest that the concept of validity, or trustworthiness, is critical:

> Validity cannot be dismissed simply because it points to a question that has to be answered in one way or another: Are these findings sufficiently authentic (isomorphic to some reality, trustworthy, related to the way others construct their social worlds) that I may trust myself in acting on their implications? More to the point, would I feel sufficiently secure about these findings to construct social policy or legislation based on them? (p. 178)

The last sentence in the above quotation goes to the heart of the issue of transferability. As discussed in Chapter 2 and in this chapter, symbolic interactionist studies are "local and specific constructed realities" (Lincoln & Guba, 2000, p. 165); they are context-dependent. It is impossible for this researcher to know the context of any future use of the data; it is her responsibility "to provide the data base that makes transferability judgments possible on the part of potential appliers" (Guba & Lincoln, 1985, p. 316). A thick description, with the widest possible range of inclusions, provides the greatest degree of assurance that future research or "social policy" may find the data useful.

Authenticity

Lincoln and Guba (2000) identified five criteria to be the "hallmarks of authentic, trustworthy, rigorous, or 'valid' constructivist or phenomenological inquiries: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical

authenticity" (Guba & Lincoln, 1989, pp 245-251). Various procedures have been developed and are available to qualitative researchers to enhance both the credibility and the authenticity of their studies. This study uses triangulation and persistent observation to ensure that the findings are credible, transferable, dependable, and can be confirmed.

Triangulation is the use of different sources and methods to provide a deeper understanding of the phenomenon. Denzin (1978) identified four types of triangulations: (a) data (by time, space, or individual), (b) investigator, (c) theory, and (d) methods. This study uses triangulation through multiple methods (in-depth interviews, focus groups, and observation). Silverman (2000) cautions that triangulation involves more than just "'mapping' one set of data over another" (2000, p. 99). He suggests that, for greatest effectiveness, triangulation should follow two basic rules:

- Always begin from a theoretical perspective (e.g., symbolic interactionism).
- Choose methods and data that will give you an account of structure and meaning from within that perspective (e.g., by showing the structural contexts of the interactions studied. (p. 99)

This study, described in the following sections of this chapter, made use of triangulation to ensure and enhance its credibility and authenticity. For this study, the richness of data yielded by these three methodologies provided enhanced understanding of how elderly individuals interpret and interact with DTC advertising.

Methods Employed

This study employed three qualitative methods, described in the following section, to better understand how elderly people interpret and use DTC pharmaceutical ads. The first portion of the study was a series of 25 in-depth, or long, interviews of individuals over the age of 65. The second methodology employed was three videotaped focus group interviews. Two of the focus groups primarily comprised women at the

older age range of the study; the third group was composed of the younger study participants. The third methodology was observation, occurring concurrently during the interviews and focus groups.

In-depth Interviews

In-depth interviews are qualitative in nature, a "guided conversation" in which the researcher carefully listens "so as to hear the meaning" of what is being conveyed (Rubin & Rubin, 1995, p. 7). From the symbolic interactionist's position, "it is axiomatic that one needs to see a social situation from the point of view of the actors in order to understand what is happening in that situation" (Lindlof, 1995, p. 30). In-depth interviews provide the viewpoint of participants and can produce a richness and depth of data necessary to allow the researcher to gain understanding, the ultimate goal of qualitative research (Lindlof, 1995, p. 30).

Long a staple of ethnographic fieldwork, qualitative interviewing is especially useful when the research topic of interest is focused less on a particular setting and more on "establishing common patterns or themes between particular types of respondents" (Warren, 2002, p. 85). McCracken (1988) describes the long interview as

> one of the most powerful methods in the qualitative armory. For certain descriptive and analytic purposes, no instrument of inquiry is more revealing. The method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can also take us into the lifeworld of the individual, to see the content and pattern of daily experience. The long interview gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves. (p. 9)

An advantage of in-depth interviews is that this methodology can provide an extended temporal range, allowing participants to share biographical information extending back decades as well as their interpretation of possible future events (Warren,

2002). With older interview participants, this aspect of qualitative interviewing is particularly appropriate and productive of rich, or thick, data.

It should be noted that in the qualitative model, the interview process is not merely a pipeline for information transmittal from a "respondent" to an "objective" interviewer. Denzin and Lincoln (2000) refer to the inquirer posture of constructivist studies as "passionate participants; facilitators of multivoice reconstruction" (p. 170). The qualitative interviewer, to some degree, participates in the phenomenon that is the subject of study. This quality of reflexivity has been described as an acknowledgment that "the methods we use to describe the world are—to some degree—constitutive of the realities they describe" (Atkinson & Coffey, 2002, p. 807). The researcher in this inquiry brings to this study an interest in and identification with the elderly study participants. A positivist approach would view this posture as a problem for objectivity and potential control issues and would prescribe artificial barriers of deception between the researcher and the participants. The qualitative paradigm, however, allows shared control, multivoice reconstruction, and a tilt toward revelation, rather than deception (Lincoln & Guba, 2000), all positions that more closely match epistemological and ethical positions of the researcher.

Interview participants for this study were interviewed in their own homes. This locale provides several important contextual benefits. The first is physiological: more than one in four (27%) individuals older than 65 yet living in the community have some level of disability in social functioning and household management; more than half (55%) of those older than 85 have such disabilities (Ham & Sloane, 1992, p. 10). Allowing participants to remain in an environment adapted to their needs increased their emotional and physical comfort levels during the interview session. It is important to

note that, while interviewing healthy adults in their 60s and early 70s is similar to interviewing younger adults, "interviewing frail and impaired people in their 80s and 90s calls for an approach that is sympathetic to the physical and mental energies" of the participants (Wenger, 2002, p. 261). Second, an interview in the context of the participant's home provides the researcher an opportunity to observe important ethnographic information as noted in the following section on "Observation."

Participants in this study observed DTC pharmaceutical advertisements in an issue of *Better Homes & Gardens*, a magazine selected for age appropriateness based on demographic data from Simmons Market Research Bureau and Mediamark Research Inc. After allowing a sufficient time to view a magazine with a large number of DTC advertisements, the researcher, with the approval of the participant, began the audiotaped interview. The following broad areas were covered in the interviews:

- The meaning of the ads for the participant.
- The importance of referent group opinions in evaluating DTC advertising.
- The degree of usefulness of DTC advertising in health-related referent group discussions.
- The incorporation of DTC advertising in interactions with physicians.

The informed consent document is included as Appendix B; the in-depth discussion guide is Appendix C. A sample transcript from an interview is included as Appendix F.

Focus Group Interviews

A focus group interview has been broadly defined as a "research technique that collects data through group interaction on a topic determined by the researcher" (Morgan, 1996, p. 130). A more specific definition is

> a small group of people brought to a central location for an intensive discussion with a moderator who focuses discussion on various issues in accordance with a general outline of question areas. (Downs, Smeyak, & Martin, 1980, p. ix)

Focus group interviews long have been a favorite investigative instrument in the non-academic arena of market research. It also is a qualitative methodology that has been used widely by quantitative researchers to gather exploratory data in preparation for a quantitative research strategy (Lindlof, 1995; Morgan, 2002). DTC pharmaceutical advertising campaigns, driven by annual advertising budgets of more than $2 billion (Barry, 2002a), have been subjected extensively to proprietary focus group research. Even if the results of these studies were in the public domain, the structured nature of the marketing group interview would yield vastly different information, more related to audience response to specific DTC drug ad campaigns, than was expected or desired for this inquiry. Morgan (2002) suggests that the main methodological difference between marketing and qualitative social science focus group research is that the more structured approaches in marketing research uses a more moderator-directed discussion with a larger number of more specific questions focused on the researcher's interests. The exception to this construct is that this less structured approach is most effective only when participants "are just as interested in the topic as the researcher" (p. 149). The solution, according to Morgan, is a recruitment process that carefully matches the participants to the research topic. The approach used in this study is somewhat structured, as evidenced by the focus group discussion guide (Appendix E). The recruitment process is discussed in a following section of this chapter.

Focus groups are a particularly appropriate methodology for this inquiry because the interactions among observers of DTC advertising could be expected to provide insights that not only amplify the data from in-depth interviews, but also to increase

understanding of how elderly women use DTC advertising in their interactions with their referent groups.

> Focus groups create settings in which diverse perceptions, judgments, and experiences concerning particular topics can surface. Persons in focus groups are stimulated by the experiences of other members of the group to articulate their own perspectives. The ways they support, debate, or resolve issues with each other can resemble the dynamics of everyday discourse. In short, the strength of this genre is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group. (Lindlof, 1995, p. 174)

In addition, the discussions among participants in these discussions provided information related to how these women used DTC advertising in their interactions with their physicians, a research venue where access often is denied.

Three focus groups were conducted, with each group comprised of six to ten participants (Lindlof, 1995). Although Morgan (1996) cautions that smaller groups may have difficulty maintaining an active level of involvement, it was found that elderly women, many with hearing and visual deficits, interacted more comfortably, and therefore more effectively, in smaller sized groups. Groups of six to eight participants were able to sit in closer proximity, which allowed participants to more clearly hear and see each other and the facilitator. Because of the prevalence of age-related frailty, Morgan's (1996) guidelines of an over-recruitment of at least 20 percent were followed. The same participant population was approached to recruit volunteers for the focus group interviews as was contacted for in-depth interview volunteers. The homogeneity of these groups encouraged interactions among participants and enhanced the sharing of life experiences. No individuals, however, participated in both the in-depth interviews and the focus groups.

This researcher, who has experience in moderating focus groups in academic and private sectors, facilitated each of the focus groups, creating an audio and videotape record of each group. This system redundancy has three advantages: first, the videotape record of the group provides a back-up for the audiotape transcription system, increasing the chance that soft utterances will not be lost; second, the videotape provides a visual record of participants' nonverbal group behavior, indicating nonverbal reinforcement, modification, substitution and regulation of group interactions (Wilson & Hanna, 1986); and third, the videotape provides a record of speaker identity, freeing the facilitator to concentrate on group interactions.

The focus groups took place on July 22 and 23, 2002. The notes, audio-tapes, and videotapes from each group were reviewed prior to conducting the next group interview. This feedback allowed the research facilitator to evaluate group responses, as well as her own prompts, for suggestions for additional questions or moderation changes for the next group.

The broad topics addressed during each of the focus group discussions were

- The characteristics of DTC pharmaceutical advertising.
- The meaning of the ads for the participant.
- The usefulness of the ads for the participant.
- The importance of referent group opinions in evaluating DTC advertising.
- The degree of usefulness of DTC advertising in health-related referent group discussions.
- The incorporation of DTC advertising in interactions with physicians.

The informed consent document for each focus group participant is included as Appendix D, and the focus group discussion guide is Appendix E. Narrative data

analysis methods are included in a following section of this chapter. A sample transcript of a focus group is included as Appendix G.

Observation

> Veteran members of a group—having long ago survived the uncertainties of initial interactions—are apt to be experts on each other's preferences, habits, and manners. As such, they normally have little need to exchange explicit information on what is already known to be part of the group's stock of knowledge. (Lindlof, 1995, p. 158)

In this inquiry, age is the principal experiential difference between the female researcher and female group participants, the "veteran members of a group" she is striving to understand. Even though the researcher shares general socioeconomic parameters and is within 10 years of the age (65) of the youngest participants, the accumulative life experiences of the participants results in a heterogeneity not found in younger cohorts (Wenger, 2002, p. 261). Just as a vast gulf can separate the language and experiences of a 12-year-old child from that of a 15-year-old adolescent, each cohort of the elderly also has its own unique history and culture. For example, older women are more likely to be widows than are younger women. Many women in the 70-and-older cohort are likely to have experienced the Depression of the 1930s as a child and married during the Second World War. Other factors contributing to a heterogeneous population are individual physical conditions: the experience (or absence) of childbirth and the absence or presence of activity-limiting conditions such as osteoarthritis and cardiovascular disease. It may be possible to speak with some authority about the "average" 2-year-old; there is far less likelihood of determining the characteristics of an average 80-year-old.

Silverman (2000) claims that observation is "fundamental to understanding another culture" or subculture (pp. 89-90), and provides two basic rules for enhancing observations:

- Record what we can see as well as what we hear.
- Expand field notes beyond immediate observations. (pp. 140-141)

The home environment where the majority of the in-depth interviews take place provides far more opportunity for knowing through seeing than the hospital environments described by Silverman (2000). Space, colors, furniture, and especially the presence or absence of family photographs all speak a highly nuanced ethnographic language. Lifetime collections of memorabilia and awards or citations from retirement functions speak to past travels and achievements. Books and hobby equipment provide a wealth of information about interests and activity levels. Bottles of pills lined up on a kitchen counter, the presence of a walker, or grab-bars in the bathroom are indications of physical illness or impairments.

Key observations for this study were made as the participant viewed the magazines containing marked DTC ads. This process of auto-driving (Lindlof, 1995) allowed the researcher to observe and note the reactions of the participants as they interacted with an ad. Initial comments to ad copy or imagery was noted and caught on tape, as well as any nonverbal reactions, such as squinting to read small print. In addition, the participant's comfort level with the researcher and the interview process was noted.

Field notes are the key to capturing this wealth of information. Expanded notes, written as soon as possible after each interview, were especially critical to retaining this data.

> Fieldwork is so fascinating and coding usually so energy-absorbing, that you can get preoccupied and overwhelmed with the flood of particulars—the poignant quote, the appealing personality of a key informant. You forget to think, to make deeper and more general sense of what is happening, to begin to explain it in a conceptually coherent way. (Miles & Huberman, 1984, p. 69)

Silverman includes Spradley's suggestion that observers keep four sets of notes:

1. Short notes made at the time
2. Expanded notes made as soon as possible after each field session.
3. A fieldwork journal to record problems and ideas that arise during each stage of fieldwork.
4. A provisional running record of analysis and interpretation. (Silverman, 2000, p. 142)

The observation protocol in this inquiry includes all four sets of notes. The researcher took brief notes during both the in-depth interviews and the focus group interviews. Expanded notes were then made after each interview and focus group session. In addition, the focus group interviews were augmented by the videotape observation data, and a fieldwork journal was kept during the entire fieldwork process. Emerging observational data was instrumental, at first informally and then during the final analysis, in creating understanding.

Interview and Focus Group Participant Selection

It is necessary to recognize the importance of age-related subdivisions, or cohorts, within the elderly population participating in this study, a population that covers a range of two, or occasionally three generations.[1] For this reason, this analysis identified and subdivided study participants into the *younger elderly* (ages 65 to 75) and the *older elderly* (age 76 and above). In-depth interview participants included both these groups, with the ages of study participants ranging from the youngest at 61 to age 90.

In addition to participants' age parameters described above, this inquiry also is further limiting the participant field based on gender. The decision to include women only is based on demographic, biological, and social rationale. As discussed in Chapter 2, women comprise increasingly large percentages of an aging population. Currently women have an average life expectancy of 80.2 years compared to 73.5 years for men (McCracken, 1998). The 2000 census revealed there were 20.6 million older women and 14.4 million older men, a sex ratio of 143 women for every 100 men. Moreover, the proportion of women increases with age, from 117 for the 65-69 age group to a high of 245 for persons 85 and older (Administration on Aging, 2001). Women, in addition to this numerical superiority, show significantly more likelihood than men to report illness (McCracken, 1998). Elderly women also have a high incidence of the illnesses most frequently targeted by DTC pharamaceutical ads. For example, osteoarthritis, a disease that primarily affects women, is the most common chronic condition in the United States (Williams & Eickhoff-Shemek, 2002). Finally, marketing has long reflected the role of women of all ages of all ages as the primary unpaid family health care provider (Graham, 1985). It was not difficult, therefore, to comply with Morgan's suggestion to match carefully participants to the research and to recruit women who "are just as interested in the topic as the researcher is" (Morgan, 2002, p. 149).

Interview and focus group participants of the study were recruited from two large multi-level retirement facilities in St. Johns and Duval counties in northeast Florida. These centers were selected based on size and relationships previously established by the researcher with either the administrator, the activities director, or through a personal contact with a resident. In addition, contacts were made with groups of elderly at several

churches in St. Johns County.[1] According to Warren (2002), respondents may be selected "based on a priori research design, theoretical sampling, or "snowball" or convenience design, or particular respondents may be sought out to act as key informants" (p. 87). This inquiry used a combination of these sampling techniques. The first volunteer participants were recruited based on (a) acquaintance with the researcher (convenience), (b) their ability to act as key informants, (c) their willingness to help locate others through their social networks ("snowball" process), and (d) their inclusion in one of the three cohort groups designated by the study (a priori research design). No incentives were offered to participate in the in-depth interviews. Incentives for this phase of the inquiry were not necessary because of characteristics of the researcher and her previous experience. Wenger (2002) notes that

> the interviewers with the highest success rates in acceptance by older interviewees are middle-aged or older women with outgoing personalities. The oldest interviewer I have used was 82 . . . those (interviews) conducted by older persons were qualitatively and empirically more complete and useful. (p. 264)

The focus group interviews were held in meeting rooms in each retirement community's activity center, and in the activity room of an area church. Participants

---

[1]Note that this inquiry blatantly uses the adjective *elderly* instead of *older* in most references to study participants. Wenger (2002), in discussing specific issues in interviewing elderly study participants asks the questions: "Who are older people, and who are they older than?' (p. 259). These questions highlight the issue of ageism, the systematic stereotyping of and discrimination against people because they are old (Butler, 1969). Because of long-standing practice in government statistics related to retirement age, medical, social, and academic research is based on the inclusion of those 65 and older in the population proportion designated as *elderly*. In an age of political correctness, a number of euphemisms have been explored as substitutes for the stigmatizing *elderly*—seniors, matures, older adults, etc. The avoidance of the term *elderly*, in the opinion of Wenger (2002) and this researcher, is stigmatizing in and of itself. "Why should being older than others be stigmatizing, unless being old is somehow a disadvantage?" (p. 259). In addition, the wide categorization completely ignores the fact that this population group covers a range of two, or occasionally three, generations.

were provided light refreshments before the interview process began. Reluctance to participate in the focus groups was not a problem because (a) DTC pharmaceutical advertising is not a particularly stigmatizing subject; (b) researcher qualities mentioned above; and (c) most older people are obliging and eager to help (Wenger, 2002, p. 265).

Prior to the recruitment process, administrators at each community center were contacted in person and shown a copy of the Approval of Protocol letter from the University of Florida (Appendix I), and the informed consent letters to be signed by study participants (Appendices B and D). Before each interview and focus group the researcher verbally explained the project, answered questions, and obtained a signed informed consent document from each participant.

Transcription and Data Analysis

The in-depth interviews began on May 21 and concluded on July 17, 2002. Both the in-depth and the focus group interviews were audio-taped and transcribed. As the interviews were completed, audio-tapes were shipped in batches to a professional service for transcription. A delay was scheduled after the first five interviews to allow time for a preliminary analysis of the first transcripts. This preliminary analysis aided the interviewer in probing for additional or deeper responses. In this way, texts were available for study as fieldwork continued. In addition to verifying each of the transcripts with the tapes, the researcher also verifed and noted each of the focus group transcriptions with the videotape of the interactions. Finally, all field notes, recorded immediately after each interview, provided observational data that added richness and additional depth of information to the transcribed interview texts.

Lindlof (1995) describes qualitative data analysis as a "process that is continuous throughout an entire study" (p. 215). The flexibility of this method allows the researcher

to capitalize on unforeseen but important information, probing in subsequent interviews for additional insights. Analysis is not a process that begins only when fieldwork is finished; it is an ongoing conceptual activity throughout the research activities. This flexibility was especially helpful in circumstances like the present inquiry, where little prior information about how the elderly perceive DTC pharmaceutical advertising was available.

Transcribed narratives from approximately 25 in-depth interviews and three focus groups yielded a voluminous amount of data. Reduction of this data was essential to the analytical process. Lindlof (1995) suggests that reduction occurs first at a physical level and then at the conceptual level. Physical reduction means to "sort, categorize, prioritize, and interrelate data according to emerging schemes of interpretation" (p. 216). Analytical coding is the process that allows the researcher to convert large amounts of data into conceptual categories amenable to analysis.

> Coding is the heart and soul of whole-text analysis. Coding forces the researcher to make judgments about the meanings of contiguous blocks of text. The fundamental tasks associated with coding are sampling, identifying themes, building codebooks, marking texts, constructing models . . . and testing these models. (Ryan & Bernard, 2000, p. 780)

Various methods of coding data-texts have been suggested (Lindlof, 1995; Ryan & Bernard, 2000, pp. 769-701). This study used the constant comparative method. Lindlof notes that key features of this method enable it to blend the four requirements of analysis: process, reduction, explanation, and theory (1995, p. 223). These features are

- It specifies the means by which theory grounded in the relationships among data emerges through the management of coding (hence, *grounded theory*); and
- It shows explicitly how to code and conceptualize as field data keep flowing in. (Lindlof, 1995, pp. 222-223)

Theory is required to create order by arranging sets of concepts to define and explain some phenomenon (Silverman, 2000, p. 78). At first the researcher intuitively attempts to create order and understanding from a wealth of concepts and relationships by analyzing and categorizing each data-set concept. As each new incident is evaluated, the researcher compares it to other tentative and emerging categories, seeking "the goodness of fit" described by Lindlof (1995, p. 223). Gradually, as categories emerge, the researcher is able to create codes—descriptions and qualifications for inclusions into a category.

As the researcher begins to identify sets of things "(themes, concepts, beliefs, behaviors), the next step is to identify how these things are linked to each other in a theoretical model" (Ryan & Bernard, 2000, p. 782). These emerging categories then can begin to be linked in theoretical models. This process orientation is critical to the development of grounded theory.

> Grounded theory is an iterative process by which the analyst becomes more and more "grounded" in the data and develops increasingly richer concepts and models of how the phenomenon being studied really works. (Ryan & Bernard, 2000, p. 783)

After the coding process was completed and a draft analysis begun, a second researcher experienced in coding and data analysis reviewed the developing codes and thematic categories. This review served as a peer audit, clarifying any ambiguities in the analysis and enhancing the credibility and dependability of the analysis.

The final phase of this process was delimiting the theory, or reaching the period when the data was "theoretically saturated" (Lindlof, 1995, p. 224) or to the point of redundancy. At this point, as further data was coded and categorized, it failed to provide additional insight or understanding. Negative case analysis, the identification of cases

that fail to fit the model, also may be helpful in aiding understanding of the theoretical limits of the proposed model (Ryan & Bernard, 2000, p. 783).

Summary

This inquiry used data from three qualitative research methodologies–in-depth interviews, observation, and focus group interviews–to increase understanding of how elderly people interpret and use DTC pharmaceutical advertising in their construction of their sense of health and in their interactions with referent group members. With little information available on how elderly people interpret and use this form of advertising, the in-depth interviews allowed participants to share decades of biographical information as well as their interpretation of DTC advertising. Conducted in the participants' homes, the interviews provided a rich source of data for the second methodology—ethnographic observation. Finally, focus group interviews, composed small homogenous cohorts, provided insights into participants' interactions with referent group members as well as amplifications of data from the in-depth interviews.

The data resulting from the above studies was reduced and analyzed according to the constant comparative method. As categories emerged, code development allowed the researcher to identify themes, concepts, beliefs, and behaviors that were theoretically linked. This process allowed the researcher to describe, with greater understanding, how elderly people, a key target audience for DTC pharmaceutical advertising, interpret and use this advertising in the creation of their personal sense of health and in their interactions with referent group members and physicians.

CHAPTER 4
ANALYSIS OF RESEARCH

> I feel positively about them (DTC ads) because it does help to make you more proactive. You're not going to obtain these drugs unless your physician feels that they are appropriate. So what is the harm in learning about them? Now there's the other question of drug companies spending a lot of money on this advertising that might be better put to saving the consumer money once the doctor has prescribed it. That's a whole other issue. [L B., 61]

> To me there is a manipulation. That's a good way to describe it. It would be very nice to look at it and say here's this person who really has something wrong with them and they don't realize there is something out there that would help them, and this would prompt them to go to their doctor and get something treated, and that probably happens and that's good. I don't think that's what happens the majority of the time. [C.L, 75]

Background

An awareness of the community and population from which this study's participants were recruited is important to understanding the analysis of this qualitative study of older women's assessment of DTC advertising.

Study Environment

All of the participants in this study were recruited from a group of older women living in northeast Florida in the eastern portion of Jacksonville in Duval County and in Ponte Vedra Beach in St. Johns County. With median incomes of almost $100,000 (Patterson, 2002), this coastal area is attracting increasing numbers of retirees.

As discussed in chapter three, this population of older, more affluent women was selected for this qualitative study for three reasons. First, older women outnumber older men (Administration on Aging, 2001), making them a significant target market. Second,

women of all ages are more likely to be the health care "gatekeepers" for family and friends, sharing symptoms, treatments, and diagnoses (Orodenker, 1991; Parrott & Condit, 1996; Wood, 1994). The third reason is economic. As discussed previously, DTC advertising has focused overwhelmingly on the "lifestyle" category of drugs—medications for chronic conditions such as arthritis, allergies and hyperlipodemia that may impact negatively a patient's quality of life without being life threatening (Bell, Kravitz, & Wilkes, 2000). Because many of these heavily advertised drugs may be considered at least partially optional in that they may not be absolutely essential for health maintenance, only those elderly individuals with at least minimal levels of disposable retirement income are productive targets for DTC advertising promoting these drugs.

As discussed in Chapter 2, the rising costs of prescription drugs impact everyone, including the population in this study, women older than age 65 and thus eligible for Medicare. For example, "medigap" pharmaceutical insurance policies, often purchased by Medicare-eligible seniors, have seen increases in copayments charged for prescription drugs similar to those charged in most employee benefit plans (Barry, 2000). Current congressional proposals to add a drug benefit to Medicare coverage include substantial out-of-pocket costs for Medicare beneficiaries—up to $4,000 annually in one plan (Steinwachs, 2002). Proposed costs in these plans include monthly premiums of $25 to $33 and varying formulae for prescription drug sharing, with one plan including a copayment of $10 for generic drugs and $40 for brand-name (and advertised) prescriptions. These rising drug costs are impacting elderly individuals already facing reduced income as a result of shrinking retirement investments. The economics of health care for the elderly are a component of the social environment of all older people, even

the relatively affluent retirees participating in this study. The context of this interaction between the self and the social environment, according to Lindlof (1995), is critical to an understanding of how older people understand themselves.

Providing services to meet the medical and housing needs of northeast Florida's aging population has become a growth industry in the area. For example, Marsh Oaks[1] (MO), the adult retirement facility home to 19 individuals in this study, is one of the highest rated such facilities in the state, according to the Florida Agency for Health Care Administration (2002). Housing units at MO include one, two, and three-bedroom apartments; assisted living units—smaller apartments where residents can receive assistance with activities of daily living; and a nursing unit. MO currently has an approximately 2-year waiting period for one of the 227 apartments in its independent living section (MO marketing director, personal conversation, September 16, 2002). [One participant was recruited from MO's sister facility, with similar costs and accommodations.] The other retirement complex from which a large number of participants were recruited, Beach View (BV), also provides three levels of housing, each designed to accommodate older people with varying degrees of assistance needs. Both facilities are options, however, only for the more affluent elderly. According to the respective 2002 marketing literature for each facility, the entry fee at MO for a typical large two-bedroom apartment in the independent living section averages $254,350. Subsequent monthly fees total $2,460 for an individual, $3,493 for a couple. BV is less expensive, with an average entry fee of $141,570 and a monthly fee of $1,463 ($2,055 a couple) for comparable apartments. Both facilities offer residents numerous benefits and

[1]The names of both retirement facilities have been changed to protect participants' confidentiality.

services, including meals in elegant, full-service cafeterias, transportation to area cultural events as well as medical appointments, on-site nursing consultation, and a range of social and therapeutic activities. In addition, both facilities are located only minutes from the Mayo Clinic Jacksonville (MCJ), where the majority of the residents receive their medical care. Most of the younger study participants—those between the ages of 61 and 75 living in private homes within the community—said that, in all probability, they too eventually will move into one of these facilities.

Study Participants

Participants in this study were recruited during May and June of 2002. As discussed in Chapter 3, participants for both the individual interviews and the focus groups were recruited by two methods—key informants and "snowball" or convenience design (Warren, 2002, p. 87). For the interview portion of the study, key informants in two senior living centers provided lists of acquaintances they felt might be potential volunteers. The researcher then contacted these women by telephone, explained the study in general terms, and invited the individuals to participate. In MO, the retirement center first contacted, requests to 32 potential participants resulted in 13 interview volunteers; in BV, the second congregate living community, telephone calls to 12 women identified as possible participants resulted in five volunteers. The remaining seven volunteers for the interview portion of the study were recruited through a similar two-step process. First, women living in the surrounding community were contacted through women's activities at two local churches. Second, these women then recommended acquaintances who might be interested in participating.

Focus group participants were contacted in a similar manner. Women participating in the interview portion of the study were asked if they were willing to

suggest names of acquaintances who might be interested in participating in a focus group discussion on advertising. Contacts generated from the interview sessions, flyers in the activity center, and word-of-mouth recruiting at the BV retirement center resulted in eight participants, ranging in age from 73 to 90, for the first focus group conducted at BV. Participants for the second focus group, conducted at MO, were recruited from contacts made during the interview portion and through word-of-mouth contacts at this facility. This group was composed of six individuals ranging in age from 77 to 91. The third group was recruited from women who had participated in an activity program at a community church or who had heard of the research by word-of-mouth from friends who had participated in the interview portion of the study. These six women, who lived in private homes in the surrounding community, ranged in age from 61 to 73. Table 4-1 provides average ages and sizes of participants in the two cohorts included in this study.

Table 4-1. Cohort size and average age of participants

	Number	Average Age
Average age of all participants	(N = 45)	77.0
Younger cohort 61 - 75	(N = 14)	66.7
Older cohort 76 - 91	(N = 31)	81.4

Emergent Themes

This study, grounded in the theoretical constructs of symbolic interactionism, attempts to understand the meanings the study participants applied to DTC advertising through the context of their socially constructed realities revealed through interviews, observations, and focus group interactions. While relevant transcript excerpts are included in the text, it is important to note that observational data was instrumental in providing a contextual framework for the analysis. From a social constructivist

perspective, these meanings have implications for future health care behavior "because it is the meaning-making/sense-making/attributional activities that shape action (or inaction)"(Lincoln & Guba, 2000, p. 167). Nine themes, as discussed below and in the following sections of this chapter, emerged in this constructivist study. These themes provide greater understanding of the meaning these participants apply to DTC advertising, how they use DTC advertising in referent group interactions, and how they incorporate the central message of DTC advertising—to take an active role in requesting specific medications—into health-seeking behavior.

Several themes emerged from an analysis of the interview and focus group transcripts. These themes, grouped under the general headings of personal health concerns, social health issues, and specific issues of DTC advertising, are discussed in the following sections of this chapter. In these discussions, the contradictions within categories and themes, both among individuals and within the comments of single individuals are noted. In addition, information gleaned from observations during the interview and focus group are incorporated where appropriate to enhance understanding and to add context to the speaker's comments. Transcripts for a sample interview and a focus group are included as Appendices F and G.

Emerging from the general category of personal health were the following themes:

- Commonalities among definitions of health.
- Estimation of personal health as superior to the health of referent group.
- Self versus physician as locus of control for personal health.

Themes grouped under the category of social health were

- Individually nuanced decisions to recommend advertised drugs to group members.
- Shunning individuals engaged in negative health discourse.

A third category of themes, more directly related to DTC advertising, also emerged. These themes were

- Conflicting assessment of DTC advertising information.
- Avoidance versus awareness of DTC advertising.
- Evaluation of DTC advertising legibility, content, and imagery.
- Complete avoidance of "brief summary" page of ad.
- Awareness of economic and liability issues related to DTC advertising.

Personal Health Concerns

Forty-three women, ranging in age from 61 to 91, participated in this study. The apparent physical health of these women, as would be expected, appeared to vary considerably, apparently diminishing with the relative age of the women. However, as will be discussed below, virtually all the women had similar definitions for "good health" and reported their personal health as "better than my friends."

Common Definition of Good Health

Despite observed differences in ages, marital status, level of education, health, and presence or lack of disability, it is interesting to note that most of the 43 women in this study shared a common definition of health. The construct of independence is embedded within many of their definitions. When asked to describe what the term "good health" meant, most participants explicitly or implicitly included the concept of ability to participate in activities of their own choice, adjusting expectations and acknowledging that with aging some levels of disability are to be expected.

As long as we feel good and are able to do what we like to do, have the energy level to do what you want, then you have good health. [N.M., 62, community]

For our age a serenity about the fact that you are in good health and don't have doubts . . . feeling like you're doing everything to cope with the inevitable aches and pains and problems that come along, because of course they're going to be there. [L.B., 61, community]

Feeling good from within, an adequate appetite, sleeping well. A good mental outlook. [L.B., 73, SJ focus group]

Living my life with joy. At the other end of the day going to bed and snuggling in and knowing that I'm going to be able to go to sleep. [M.R., 69, SJ focus group]

Good health means to be able to do what you want to do and feel that you are capable of doing it and to do it without pain. [C.L, 75, BV]

It means the ability to function and that we have accepted a responsibility of having a certain disorder as we get older and functioning with that disorder to the best of our ability. [M.A., 73, BV focus group,]

It's a state of well being without too many aches or pains. I think at my stage in life you expect a certain number. Being mobile. Being able to engage in a certain amount of exercise. [P.H., 79, MO]

It means feeling well and leading a normal life and a sense of well-being. [B.J., 84, MO]

It means doing what you want to do. Up until last year I played golf twice a week and went to the gym every other day that I didn't play golf. I had to stop because I have glaucoma and I have a depth perception problem . . . I had to quit. [B.C., 80, MO]

It is interesting to note that a realistic acceptance of the frailties that often accompany aging were integrated into several individuals' definitions of good health.

(Good health is) Feeling good. At this age you wake up in the morning and you have a new ache somewhere, but being able to do the things that you want to do and feeling like doing them. [C.B., 81, MO]

I have severe emphysema. I have severe osteoporosis. I still feel good. I can still do a lot. I can still enjoy life. [L.M., 73, BV focus group]

> I'm 90 and I sleep a lot. I remember my husband who died in 97 slept a lot the last few years. Aside from that, I don't hurt . . . I'm in good health. For 90. [L.R., 90, BV focus group]

Estimation of Personal Health as Superior to Health of Referent Group

The younger women, especially those not yet 70 and living in private homes in the community, reported, as expected, a considerably higher level of physical activity than did the older women. Many of these youngest participants reported weekly activities of golf, tennis, or exercise classes. Conversely, many of the older women—certainly most of those age 80 and older—reported multiple coexisting chronic conditions such as arthritis, heart trouble, high blood pressure, and diabetes.

In spite of the varying degree of apparent health, most of the participants self-reported their health as excellent, or at least better than most of their friends. When asked, "How would you rate the status of your own health on a scale of 1 to 10?" many of the participants, even those with some degree of observed physical disability, claimed their health to be "excellent." Conversely, several of the younger participants, who appeared to be in relatively good health, rated themselves somewhat lower than individuals in their 80s.

> I have been healthier. But I think really I'm coming back. I feel good when I get up in the morning. So, probably eight. [M.R., 69, SJ focus group]

> I'm a 10. I'm a 10 in spite of arthritis and artificial knees and overweight. . . . One thing is I'm younger than a lot of my friends . . . (I'm 74) I don't think of that as all that young except around here, it's like wow, so many of my friends are 85 and they be-bop along and it amazes me. [C.L., 74, BV]

> I think I'm probably a little more active than a lot of them and in better health generally. [P.L., 80, MO]

> Better if they (friends) are anywhere near my age. A lot of my friends are younger. [J.B., 80, Community]

> They have a lot more energy than I do, but I just do what I can and then I stop and rest. [CB, 81, MO]

> I think I'm better, more healthy than a lot of them my age. There are a few 90-year-olds around here. One of them teaches the swimming class. I think she is 92. She is asking me to go. [J.G., 82, MO]

Self Versus Physician as Locus of Control for Personal Health

In this study, the most pronounced difference found between the attitudes toward DTC advertising of the younger members of the study and those of the older participants was the degree to which the older women depend on and trust in the judgment of their physician for drug choices. The younger participants accepted more responsibility for self-education and risk assessment and appeared to be more willing to confront their physicians over differences in treatment issues.

Some of the older participants in this study defined "confidence in your doctor" (C.E., 78, MO) as a required component of the construct of "good health." When asked to evaluate DTC advertising, CE added,

> I think it (DTC ads) may be useful for people who don't have a doctor they have confidence in. It may give them some hope for their condition they wouldn't have otherwise.

The basic premise of DTC advertising, as discussed previously, is to persuade individuals to perform one essential behavior—to ask their physician for a prescription for a branded product. While most of the younger women in the study expressed no reservations in requesting an advertised drug from their physician, many of the older women expressed a decided reluctance to perform this behavior.

> I would certainly talk to him. I would not hesitate to bring it up. Seeing all these ads on TV and in print make all of us very aware of the drugs that are out there. And I would not hesitate to ask the doctor if I thought that something might be appropriate. [L.B., 61, community]

> I don't approve of medicine being advertised. I let my doctor decide . . . [E.T., 78 BV]
>
> The advertising will tell you it's the best. The other company will tell you theirs is the best. And I think you have to go to your doctor and do what the doctor says. [M.H., 80, MO]
>
> I wouldn't think of doing it. It would never occur to me. I assume he is knowledgeable and up-to-date. Hopefully. [M.A., 73, CV focus group]
>
> I wouldn't ask him for a prescription, I would ask him what he thought. I would never tell a doctor what I wanted. I would ask him if he thought if that was one of his choices. [M.B., 81, MO]

Another participant, who had just evaluated DTC advertising as "helpful," went on to say

> Well, it scares you when you hear all of the cautions, the risk and the warnings. But I think we need to know them, but it does sort of scare you because you say oh, my gosh, if it has that many things, then you think 'is it okay?' and I will ask the doctor if it's okay. [W.F., BV, 77]

A member of another focus group concurred.

> If I have a problem, I go to the doctor and take what he recommends. I don't say what about something I've read in a magazine or that I've heard on television. I wouldn't either. [B.D., 89, MO focus group]

On the other hand, some participants expressed a conflict within themselves between their desire for their doctor to "be in charge" and their desire for the latest advances in pharmaceutical care. For example

> I would not presume to say (to my doctor) 'shouldn't I be taking this' or 'that would be good.' I wouldn't ask . . . I suppose if I had something serious and if there was something new out there (I would make a request). [E.T., BV, 78]
>
> I'd rather have my doctor recommend things. Let's go back to the way we were before 1997 and have the doctor recommend things. [M.H., 80, MO focus group]

Several individuals expressed a desire for their physician to be able to resist requests for prescriptions that might not be in their best interest.

> I want to think that I could not pressure him into giving me a medicine because I wanted it. I don't want to think that he would just because I asked for a medicine. And I think . . . there are some that would . . . I think he would be more resistant to doing that than some are. [C.L., BV, 75]

> I wonder if doctors are persuaded to prescribe a drug that they're not thoroughly familiar with? [J.F., 80, MO focus group]

Although the older women were more likely to express reluctance to request information or an advertised drug from their physician, it cannot be said that they have a passive attitude toward their own health. In fact, many older women were almost as likely as the younger women to accept that good health is at least partially dependent on personal choices.

> (My health is) Very good for someone my age with all the medical problems I have. I think it's very important that a person take care of themselves. Unless you get out there and walk nobody is going to do it for you. Discipline. [C.E., MO, 78]

> I have one friend who is five years older than I. She never stopped smoking and she's on oxygen. A lot of that is self-induced. I'd say my health right now is very good compared (to hers). [M.B., MO, 81]

A realistic, rather stoic view of aging was pronounced among a few of the oldest women.

> If I get cancer, I don't see any reason to start on serious chemotherapy. Not at 82 . . . I'm not afraid to die. [J.G., MO, 82]

> People fall. That happens (here) frequently. . . . They break a hip, an arm, a knee. Knee things they seem to replace. . . . We all die in the end from a heart that gives out. You can have other things but when your heart stops beating you pass away. Which physical ailment you have to you may be the most severe one. I'm very concerned about what I have. . . . There are people here who don't exercise at all or even get the mail. I do a lot of housekeeping. I change my own bedsheets. The maid will do it and most people here let the maid. I do it for exercise. [E.F., MO, 84]

Several women, of varying ages, appeared eager to embrace DTC advertising as just one more source for health-related information that would enhance their lives.

> It's encouraging to see people my age and older in advertisements running along the beach, laughing, enjoying life. I think that's good. [C.E., MO, 78]

> We have been taught, and we have been given the impression that this magic potion is going to make us younger and more appealing. [L.B., 73, SJ focus group]

Social Context of Health Issues

Individually Nuanced Decisions to Recommend Advertised Drugs to Referent Group Members

Although a few participants reported that under no circumstances would they recommend an advertised drug to other members of their referent group, most participants appeared to evaluate the appropriateness of drug discussions based on the degree of closeness in their relationship with the referent group member. Those who reported willingness to discuss drug information with others outside their physician's office were most likely to have conversations with members of their immediate family.

> It would catch my attention the most if it pertained to my family personally. . . . Every time I see something on diabetes, for instance, I go to my husband immediately, and we even write down the name of the drug if it sounds promising. [N.M., 62, community]

> My daughter is a juvenile diabetic. I would read those more. . . . I cut out things and send them to my daughter. [Would you recommend?] To my daughter, yes I would. Nobody else.[B.S., 78, MO]

> I think my sister has (asked physician for advertised drug). She asks her physician about a lot of things. . . . She pursues that more than I do . . . I take Vioxx and I'm sure it's because I kept complaining of muscle joints and so on. . . . My sister takes Celebrex, so we don't know why we're on the different ones, but it seems to work so we just stick with it. [P.H., 79, MO]

> My husband has (health problems) but he doesn't read them (DTC ads). I suppose if I saw anything that would apply to him, I would read it, suggest it and maybe he would ask our doctor. [J.B., 80, community]

> I've been very close to my son since this emergency surgery. He's shared some drugs with me. Yes, I might ask (him) about something. I don't think I have. [E.F., 81, MO]

> My brother has had shingles for 18 years, and he wasn't in time for that new medicine. So every time I read something about shingles, I'm always clipping and sending things to him about it. [B.J., 84, MO]

On the other hand, perhaps due to a reluctance to appear a "burden," a few individuals reported that they found it easier to talk about health problems with friends than with family members.

> (I talk) with friends. Not very often with family members. I have one son. He has an extremely sick wife who is terminally ill and has been for 16 years. We just don't talk about those things. I'm not going to burden him with anything on my mind. [B.C., 80, MO]

The degree of comfort in discussing health-related issues with nonfamily referent group acquaintances appeared to increase as the age of the participant decreased. Although many of the older participants appeared to feel that such discussions were inappropriate, there was recognition at all ages that such conversations were a frequent occurrence.

> I have a friend whose husband has been going through quite a depression. And I remembered seeing the ad for an anti-depressant. . . . You have to be a pretty good friend because quite often they talk about sexual side effects. . . . I would be comfortable. [L.B., 61, community]

> Since I have migraines and I know other people that do have migraines, since we have a common interest, I would probably be more likely to tell the person.
>
> [N.M., 61, SJ focus group]

> Or ask them if they have tried it. [several participants, SJ focus group]

> Or if they knew about it. [L.B., 73]

> Their print (DTC ad copy) is not very outstanding. . . . Perhaps it doesn't need to be these days because everyone is so familiar with these drugs. We hear about them and see them so often that we discuss them. It's cocktail party discussion--who's taking what. [L.B., 61, community]

> I don't know how many people have told me recently they are taking Celebrex . . . there's one that begins with . . . Vioxx, that's the one I'm thinking of. I mean you hear it, that's everyday conversation, those two are . . . .(Do you recommend a drug you have seen advertised?) I would encourage them to go to their doctor. I wouldn't give them the name; I would say there is help for that. That's my style. [C.L., 75, BV]

> I think they would be responsive. It depends on how good of a friend you are. I'm very cautious about recommending anything I haven't actually tried myself. [D.S., 81, BV]

> I would suggest they go to their doctor. I just think that's the way to handle a situation if you are having a problem. [M.B., 81, MO]

> Oh, yeah, they talk at the dinner table all the time about, or take this medication for this and this medication for that. I don't play the organ anymore because I have arthritis so I keep getting asked to play and I will say (that I have arthritis), and they will say, well, if you would take such and such you wouldn't have that. [D.S., 81, BV]

Some individuals denied ever having referent group discussions related to DTC advertising unless the ad itself was considered notably annoying.

> Not really (discuss DTC advertising), unless it would be something sort of annoying or not tasteful or something. [P.H., 79, MO]

Other women, especially those living in the retirement communities, acknowledged that their referent groups provided a pool of useful health-related information.

> In the case of my knee, everyone here has some kind of joint problem. You exchange information, maybe someone has tried some kind of method. I don't go to the Internet. I'm sort of computer illiterate. So here is a great source right here of information on various and sundry problems and ailments which people don't mind discussing if they're asked. I don't mean that they go around talking about their problems all the time. I asked people that I knew that had had knee replacements what their experience was and who did it and how much rehab or how long it was going to take. [P.H., 79, MO]

Shunning Individuals Engaged in Negative Health Discourse

Various participants expressed a strong desire to avoid health-related discourse. This attitude appeared to be especially prevalent among the older participants living in one of the retirement centers.

> A few years ago, we were at a dinner party. People were all sitting down . . . and the hostess came and said, 'You all quit talking about your health.' All of a sudden, dead silence. We couldn't think of anything to say. [M.H., 80, MO focus group]

Individuals who disregarded messages to change the conversational topic, apparently did so at the risk of social ostracism.

> One reason I don't like to eat with certain people is that all I hear is their ailments and their drugs and their this and that. [D.S., 81, BV]

> If you find people who talk too much about their health, we don't see them. We don't invite them to join us. You know who they are. . . . It becomes a bore. Everybody here has some kind of problem. I would be the exception. If we sat around and everybody talking about their health problem and what drugs they take and which doctor they go to, we'd be a nightmare. It wouldn't be any fun at all. [E.F., 81, MO]

> If you think anybody can live in a retirement home and not hear about everybody's ailments 24 hours a day, that's all you hear about. We got together and decided whoever turns the subject to their own health, they have to put a nickel in the pot. [B.J., 84, MO]

Themes Specific to DTC Advertising

Conflicting Assessment of DTC Advertising Information

DTC advertising provides useful and empowering information. Many study participants of various ages positively evaluated the DTC advertising as useful and educational. This positive perception of DTC advertising usefulness, however, often was related to the advertising's degree of relevance to their personal health issues. While younger women generally were more likely to express belief in the educational usefulness of DTC advertising, many older women also placed a positive value on the information contained in DTC ads and suggested that information obtained in the advertising facilitated their interactions with their physicians.

> I've got to tell you, my feelings is if you have migraines and some new drug has come out, no matter how bad the ad was you would pay attention because migraine sufferers are desperate. [M.M., 63, SJ focus group]

> I have fever blisters. If an ad came out and said this is the new great cure for herpes, I got to tell you I don't care how bad it was, I would read every tiny little word because that is my particular problem . . . the cold sore. [MLM., 61, SJ focus group]

> I like having additional information which I can ask my doctor about. When I have done this, my doctor has actually said, "let me look into this." [N.M., 62, community]

> I feel positively about them because it does help to make you more proactive. You're not going to obtain these drugs unless your physician feels that they are appropriate. So what is the harm in learning about them? [L.B., 61, community]

> It (DTC advertising) goes into detail explaining all about why you should use it and what happens and so forth, and that is so important with any medication. Especially for women because they want to know all of these things and they don't always have it explained to them. . . . That's one of the things with the doctors and the medical field, I don't think they give enough explanation with what a person is supposed to do on whatever the drug might do or whatever. [W.F., 77, BV]

> I think the ads are valuable from the standpoint that it does give you an opportunity to sit down on your own time and read and find out stuff that you would not have found out, so at least when you go to your physician you can ask a question. (Agreement expressed) [N.M., 61, SJ focus group]

> I might think, gee, I feel like that, maybe I've got that. So I go and ask my doctor and she says no, you don't have that . . . I don't object to the advertising because it does bring some thoughts to your mind to ask your doctor about. If you're taking something, you say, oh, I take that. I think it's good. [C.B., 81, MO]

> I think that it's probably very good because it brings to your mind new products, but anyway it makes you aware that there are treatments for things that might affect you and your condition, your health. I don't make that many regular calls to my doctor; something like this might jog something in my mind. [P.H., 79, MO]

M.B., an 81 year-old widow, expressed an acceptance of advertising as an educational tool. Her comments illustrate the difficulty of assigning older people to narrow, age-defined categories. When asked about her opinion of Viagra ads,

> I personally think it's wonderful. If there's something missing in their relationship that they can help the cause along. So many people thought that was terrible with Bob Dole. I didn't see anything terrible about it; I thought it was wonderful that people realized just because you're his age you're not ready to curl up. I think it's great if that is helpful and helpful to your marriage situation. [M.B., 81, MO]

Several of the younger participants also expressed a feeling that the benefits of newer lifestyle drugs outweighed any associated risks, and that the removal of stigma associated with conditions like "E.D." (impotence), depression, or incontinence was a positive benefit.

> I only have a few words. My words are better living through chemistry. Anything that makes me feel better, even if there is a degree of risk, I'm willing to take risk. I smoked for 30 years, I'm no sissy. [M.L.M., 61, SJ focus group]

> I think a lot of these things that are being advertised now are definitely out of the closet, like the Viagra. That certainly wasn't a conversation that you would have with mixed company or anything like that. Depression, all these things are things that are now being out in the open. The same thing with the one about the lady . . . I got to go, I got to go, the bladder problem. [S.S., 62, S.J focus group]

Manipulative, tasteless, inappropriate, or frightening information. Several younger participants expressed a belief in negative consequences to advertising information. DTC advertising, in their opinion, was inducing more and more people to reach for a possibly unnecessary pill. The following statements were not elicited from a direct question, but emerged during the discussion among the six SJ focus group participants, ranging in age from 61 to 73.

> We have been taught to take the medication for every ailment that comes along. If we have a headache we rush to the medicine cabinet. If our toe aches we go look for something for that. I think through advertising this is a concept that has been taught to us and our children and the next generation down. Certainly my parents never had this concept. [M.A.M., 61, SJ focus group]

> Your boobs are going to look better. [L.B., 69]

> That Detrol or whatever, your urinary problems are going to go away. [S.S., 62]

> Everything is going to be fun if we do this. [M.M., 63]

A 63 year-old woman interviewed in the community reiterated the concerns voiced in this focus group.

> In general, I think the average ad does a disservice to people. They're teaching us to be aware of every kind of symptom, and so many things you can just overlook and the next day they're gone. So I think they're really pushing too many things at us. I do find that very disheartening. Very annoying. And if you're prone to do that, it's causing people to worry more about their health. [C.H., 63, community]

Other, older participants also expressed disapproval for the explicit purpose of the DTC advertising—providing a message to persuade people to ask their physician for a prescription.

> To me, there is a manipulation. It would be very nice to . . . say here's this person who really has something wrong with them and they don't realize there is something out there that would help them and this would prompt them to go to their doctor and get something treated. That probably happens and that's good. I don't think that's what happens the majority of the time. [C.L., 75, BV]

> They (friends) don't like them (DTC ads) . . . it's the same sort of thing that we don't like lawyers advertising. The world would be so much better off without advertising. [E.T., 78, BV]

Perhaps more seriously, several participants expressed disbelief in the side effects listed in DTC advertising, claiming that repetitiousness lessened believability.

> The warnings are so terrible that I don't think you'd ever take it if you listened to all those warnings. [W.G., 80, MO]

> It tickles me that they all have the same side effects. Nausea, headache, stomach cramps. No matter what you take, you're going to experience something. [L.B., 61, community]

> They're easy to understand except that all of them have so many side effects. It makes you frightened about any of them. [B.D., 89, MO focus group]

> But I do think that all prescription medicine nowadays lists every possible thing that could happen to you. You almost wonder if you should bother. [M.B., 81, MO]

Avoidance Versus Awareness of DTC Advertising

Another difference noted between the younger and older women in this study is that media exposure, especially reported magazine readership, appeared to have an

inverse relationship to age. In other words, the older a participant's age, the less likely she was to report subscribing to or purchasing magazines. When magazines are read, most participants of all ages claim to attend only to those ads for prescription medications for conditions they or a key referent group member may have.

> I notice it if it's something I take. [J.F., 80, MO focus group]
>
> I don't really read many of them except things that I take myself I read, just because I take the medicine. . . . If I take it myself or have a very good friend who's on the medication, I may be curious about it. [B.J., 84, MO]
>
> I probably wouldn't pay much attention to the advertising. I think if I were a victim of one of these things then I'd probably read all about whatever helps. But I don't have diabetes, at least so far. [M.B., 81, MO]
>
> I don't read them unless I have taken them. I'll glance at them. Most of these today have strange names. The newer ones. That throws me. It's all the new generation. [B.S., 78, MO]
>
> I've never read through the fine print . . . it's a personal thing. I've never had a migraine headache. So I wouldn't pay a whole lot of attention to it. I'm awfully glad it's out there for people who need it. [L.B., 61, community]
>
> If I saw the ad and it was something I thought I needed, I would (ask physician about the drug) . . . I think most of it is a waste of time. Unless it's diabetes that I followed up on. [B.S., 78, MO]

Many of the same women who claimed to read very few magazines reported a familiarity with the print ads because they had seen advertising for the same product on television. Television advertising, like print advertising, usually appeared to be attended to only when the product was relevant to the individual's needs.

> It happens that none of the ones we saw in here pertains to any problem I have. I don't pay attention to them. . . . I look at this and just flip the page or flip the TV and leave the room for a minute. I don't mean I'm totally anti. It just doesn't affect me. (E.F., MO, 81]

A contradiction was found within the statements of several individuals. When first asked to identify a common prescription drug ad, many of these individuals claimed

not to be aware of any specific ads. When prompted, however, certain brands would come to mind. Likewise, an individual who claimed to watch only "C-Span, History Channel, and Discovery" [J.G., 81, MO] was familiar with television advertising for Lipitor. Another patient who claimed that "I don't pay too much attention to them" [R.W., MO, 80], claimed shortly thereafter that she was taking a drug as a result of seeing an ad, "That's when I saw the Evista advertisement that said why not change."

Occasionally, the presence of television advertising was acknowledged—but as a ubiquitous nuisance, not as a helpful source of information.

> (I notice) the ones on television. You can't avoid it, no matter what you're watching. Half the time I don't know what they're advertising. I'm not the only one that feels that way. I've heard of this Zyrtec. They can say so much more on paper than they can in a 30-second ad on television. [B.C., MO, 80]

> I just don't pay any attention to it, except for the fact that they come out with so many things that are so personal while I'm eating my dinner and I don't like that. [P.K., MO, 80]

Some of the older participants appeared to view DTC advertising, on television and in print, along with professional advertising by attorneys and physicians, as an unpleasant and inappropriate intrusion of modern marketing.

> Doctors and lawyers, which is a horror scene; no one would have ever done it in my generation. Doctors shouldn't have to advertise, they have more patients than they can handle. Same thing with these drugs, they're prescribed by the doctors and I don't think it's necessary to have that much advertising. They should be sold through doctors and hospitals rather than through media. [B.J., 84, MO]

> I pay attention because they annoy me. [M.H., 80, MO focus group]

Evaluation of DTC Advertising Legibility, Content, and Imagery

Print size and comprehension. While most of the study participants reported relative ease with the type size in the body copy of most DTC magazine advertising, when questioned further, many said that the body copy, as opposed to the headlines and

subheads, often was too small. Virtually all participants directed to the "brief warning" page, or the second page, of print DTC advertising, claimed that the type size was too small for comfortable reading. Observations made when participants specifically were requested to attempt to read the "brief summary" page revealed such behaviors as holding the page at various reading distances, adjusting eyeglasses, and squinting. Comments related to the main body copy include

> I have to have my glasses or I can't see any of it but no . . . they've got it in a larger print here, which is wonderful for older people . . . I like the large print for the most important things and then the print that's larger than that little tiny stuff in this area about the warnings. [W.F., 77, BV]

> That's too small really. I would think, I don't know what Lipitor is for, oh, high cholesterol, but this is awfully small. [D.S., 81, BV]

> I have never read the complete page. I tend to read the sections that are bold. The size of the print is a problem as you get older. [N.M., 62, community]

> The language is good, understanding. I wear glasses but I can still read it without the larger print . . . not the small print. [J.B., 80, community]

A few participants complained of having comprehension problems related to over-complex language in the main body copy of the ads.

> They use words and medical language, but most of us don't know what it means. [P.W. 89, BV]

Most of the participants, however, appeared to understand such issues as indications for the advertised drug and potential side effect warnings. It should be noted, however, that participants in this study all were high school graduates; most had completed at least two years of college.

> It's (Datrol) a good ad. . . . It's very clear and precise. [M.B., 77, MO focus group]

> The written language. I would say it's easy to comprehend. They go into the business of what they say. [R.W., 80, MO]

> I think it (language) is easy to understand and pretty explicit. It might be a little long. [N.M., 62, community]

> They're easy to understand except that all of them have so many side effects. It makes you frightened about any of them. [J.F., 80, MO]

Some participants noted that when negative or risk information is embedded in the middle or toward the end of the body copy, the message went unheeded.

> Well, they say the bad news and that gives you a warning right there and they go on to say the good news is that if diet and exercise aren't enough, then add Lipitor, but I don't think I would get that far down into it on that particular ad. [D.S., BV, 81]

Graphic content. Participants expressed decided, yet highly individualistic, opinions about visual elements in the ads. In particular, several participants pointed with pride to artwork hanging in their apartment, claiming, with some degree of validity, to have an 'artistic' background and thus were drawn to the visual elements in an advertisement. These participants often provided a detailed critique of graphic elements within the ads. Several of these women, among other participants, noted that the print ads appeared to contain more memorable information than television ads within the same campaign.

> Seeing (print) ads, their names are familiar from television but seeing the ads you have more of a mental picture. You're more aware of what the product is and what it does in magazines as opposed to television . . . I think it has more impact than a passing image because if it catches your eye, you do sort of follow up with reading about what it does. [P.H., MO, 79]

> I'm a visual person. . . . The layout and the photographs, that's a very important part of appeal . . . as far as I'm concerned. [E.T., BV, 78]

> The double spacing makes this part very easy to read. [C.L., BV, 75]

> And of course the color of ink, this could be darker. See how nice and dark this is? Why is this light? Of course, that's the artistic approach. They think that if they change the colors it will help. [D.S., BV, 81]

Occasionally, a few of the participants expressed an emotional reaction to the visual imagery alone. The most positive reactions were to graphic elements that included children, pets, and flowers.

> I like flowers and I like the ladies over here . . . I see heart attack or stroke and my husband has a history of stroke. . . . The picture just grabs you. To me it, and the colors appeal to me, yellow flowers appeal to me. [C.L., 75, BV]

> That is an appealing ad for Zyrtec. The dog is cute and the child is cute, you don't just skip right over it. [B.J., 84, MO]

> Look at that adorable little fellow and that adorable little girl. Two-thirds of the page is a picture of a little girl and a dog. That's where your eye goes first. [L.B., 61, community]

> That's an interesting ad. It's different from most. It's unusual to see real people. I think there's something about the ad context, the text, that's very dignified. I like that. That's definitely top row advertising, more high class. I know so many people take this drug now. I wish they'd take the price down.

Some participants expressed a dislike for certain subjects in DTC advertising imagery.

> [sarcastically] The way she's jumping happily over the place. She's taking Celebrex, and it doesn't bother her in the least. She feels so great and all that kind of stuff. [B.C., MO, 80]

> Well, some of it is repulsive . . . especially the medications on weight reduction. They will show a person that's so obese, and I don't know, some of the presentations aren't as attractive as others. [D.S., 81, BV]

> Usually you see how romantic the couples are (in Viagra ads). . . . Maybe I find it a little embarrassing, although I think it's the greatest drug. I don't want to see older people looking foolish. [C.H., 63, community]

Other participants suggested content and imagery changes they thought would increase an ad's ability to convey critical information.

> (Referring to a Lipitor ad) See cholesterol is played down. If this were my ad, I would have a picture of arteries congested and almost closed with plaque. . . . Just looking at that, I thought it was going to be insurance. [HT, 77, community]

Celebrity testimonials. The effectiveness of celebrity testimonials was noted by many of the study participants. However, it also should be noted that for all ages of study participants, generational homogeneity between celebrity and target market, rather than gender or race, appeared key to the effectiveness of this ad content. On commenting on an ad for Altace, B.S., 78, comments

> That's the one with Jack Nicklaus. I have seen that. Heart attack, stroke. It does everything, doesn't it? I've seen this ad on TV. I just wouldn't switch.

> Celebrity ads are interesting. Who's the golfer that does? The golden bear, Jack Nicklaus, does an ad for something called Altace. I will be darned if I can figure out what that's all about. I think that's the most confusing ad I've ever seen. [L.B., 61, community]

Several participants expressed an opinion that the combination of sound and action in video DTC advertising lead to appeal and recall. In one discussion of a celebrity testimonial used in a national integrated marketing campaign, an 80-year-old commented

> I'm thinking television. Jack Nicklaus because you can hear his voice anywhere and recognize it anywhere. He has a squeaky voice for such a big man.[B.C.,MO]

Women ranging in age from the early sixties into the eighties reported a positive response to the testimonial appearance of the black singer, Patti LaBelle, in an ad for Prempro, a hormone replacement therapy.

> Well, they look so good. That's what they've chosen, a woman that you know that is a little older. Boy, does she look great. She looks young. Her skin looks nice and smooth and shiny. [M.M., 63, SJ focus group]

> I would say that was a very good ad if I were rating it. She's (Patti LaBelle) well known. She's not my favorite singer, but I know who she is. [J.B., comm, 80]

> Now, when she says at the bottom this is Patti's personal experience. Not all women have the same experience with menopause. I think the average person is going to skip over that part. If they're interested in taking Prempro because she's telling them, they don't want to hear anything negative. [L.B., comm, 61]

Even when the model is not an identifiable celebrity, some participants expressed awareness of congruity between their age and the model's apparent age.

> She doesn't look young. She looks . . . sort of like somebody I would see out in the gardens in Macon working in their garden . . . sort of *Driving Miss Daisy*. . . . I really don't think she is as old as I have imagined her, but I just saw an older person working in her garden. . . . I don't know, that ad appealed to me. [C.L., BV, 75]

Many women expressed a negative opinion of the use of celebrity testimonials in the Viagra campaign.

> Viagra, of course, especially starting with Bob Dole, which drove us all nuts. [L.B., 61, community]

> Robert Dole, very annoying. It tickles me, too. Of all the things that Medicare won't pay for, they'll pay for Viagra. [M.H., 80, MO focus group]

> I guess I would say Viagra because you see their advertising everywhere. They have done a good job of using both high profile people and everyday people to show that this does not have to be a hush-hush thing. [N.M., 62, community]

Others, however, rejected the basic premise of celebrity testimonials in DTC advertising.

> Just because he is well known or can sing, he can't tell me what I should be taking. [J.B., comm., 80]

Complete Avoidance of "Brief Summary" Information

At no point during this study did any participant, regardless of age, voluntarily begin reading the print on the "brief summary" component of any ad (Appendix H). As described previously, when directed to the page and asked to read it, almost all participants were observed squinting, adjusting the page distance, or shifting or changing eyeglasses. Most participants verbalized that the print size was too small for ease of reading on the majority of such pages. When participants were directed to the "brief

summary" page and asked if they had ever read the warning information, typical answers were the following:

> I would never read it here ("brief summary")….I consider this their legal protection more than I do its sales. It seems to me they are spending their money for their legal protection. [C.L., BV, 75]
>
> I don't pay any attention to that. I probably should and I don't I have it well explained to me. [B.J., 84, MO]
>
> Sure, but not what's on the back (referring to the direct warning portion of the ad). If it was on the front I would read it. Not the fine print. [B.C., MO, 80]
>
> Fine print some of the people can't read it, and the use words and medical language, undoubtedly, but most of us don't know what it means. [P.W., 89, BV focus group]

Another focus group discussed the "brief summary" page.

> Who can read that little print? [J.S., 84, MO focus group]
>
> I'd have to take a magnifying glass. [M.H. 80]
>
> They do that to satisfy the law. [J.C., 84]
>
> I could read that. [M.B., 77]
>
> It's pretty dull. [J.F., 80]

Even the youngest participants complained about the print size on the "brief summary" page.

> Its (print size) too small. The average person, unless they're looking for something specific that relates to them, is probably not going to read this. You're going to skip over it unless it really relates to something that's going on with you. [L.B., comm, 61]
>
> The age group that they're reaching, it makes a big difference because almost all of us have to wear glasses. [S.S., 63, SJ focus group]

Awareness of Economic and Liability Issues Related to DTC Advertising

Many of the participants evidenced an awareness both of the economics of pharmaceutical marketing and the realities of legal liability. The cost of drugs appeared

to be a concern to many participants, regardless of their relatively higher income levels. Participants also were aware of the variance in cost between generic and branded drugs and expressed opinions concerning the practice of introducing new proprietary brands to replace older drugs moving off-patent to generic status.

> I guess I'm annoyed because it's (Nexium) such an expensive drug to begin with. I lump Nexium and Prilosec together. It's the same company . . . it was time for it to be generic. [E.T., BV, 78]

> That's another thing, the generic drugs. Pharmaceutical industry is trying to block the registration of drugs. Once they're registered, the generic people can come in and do it. [J.F., 80, MO focus group]

> It's a lot cheaper, generic. M.B., 77, MO focus group]

> Now there's the . . . question of drug companies spending a lot of money on this advertising that might be better put to saving the consumer money once the doctor has prescribed it. [L.B., comm, 61]

> We know how much these ads cost, three-page ads, 30-seconds or a minute on TV is terribly expensive. [M.H., 80, MO focus group]

> I feel that advertising in magazines such as this and newspapers and on TV is definitely one of the reasons that drugs and medications and prescriptions are so expensive and keep becoming more expensive. [E.F., MO, 84]

> Most of it we don't believe. . . . They say this is why the price of drugs becomes so high, advertising. [B.S., MO, 78]

> I'm sure it (DTC advertising) pays off very well for the drug people. Otherwise, they wouldn't be doing it. I know I have quite a lot of stock in various drug companies. I hope they are doing well. [R.W., MO, 80]

> My two sons are both on Lipitor, my husband was on it, I am on it and the only reason we take Lipitor over Zocor, I've discovered when I was going through my insurance that the Lipitor would cost half of what the Zocor would and I talked to my doctor about it; I didn't do it because of the ads on TV or here. [C.L., BV, 75]

One participant reported attending to television drug ads, however, with special attention to pricing information.

> It shows the number you have to call to order. You can get it from them. I just want to call and find out if it's cheaper. (L.W., MO, 85]

Participants expressed recognition that much of the language contained in DTC advertising was driven by legal liability defense as well as by regulatory agencies.

The pharmaceutical company is protecting themselves. I think they covered the waterfront. . . . They just don't want to be sued. [H.T., 77, community]

That's (brief summary page) what they have to put in to satisfy the law. [M.B. 77, MO focus group]

Summary

The following chapter of this study provides an overview of the conclusions related to this qualitative study of the context and meanings of DTC pharmaceutical advertising in the lives of the study participants. This analysis will ground the study conclusions in the theoretical approach of symbolic interactionism, illustrating the usefulness of this phenomenological approach to an investigation of the research questions driving this study. The methods used will be reviewed for issues of credibility, trustworthiness, and authenticity. In addition, the weaknesses inherent in this methodological approach will be discussed, including a discussion of the limitations of the study population. Finally, productive areas of future study will be identified, along with potential practical applications of the study

CHAPTER 5
DISCUSSION

> I feel that advertising in magazines such as this and newspapers and on TV is definitely one of the reasons that drugs and medications and prescriptions are so expensive and keep becoming more expensive. (CF, 84)

> I hate to be so critical, but these aren't the world's greatest ads, are they? They (Lipitor ads) should appeal to me, this is our family, we have a problem with that. My two sons are both on Lipitor, my husband was on it, I am on it and the only reason we take Lipitor over Zocor, I've discovered . . . that Lipitor would cost half of what the Zocor would and I talked to my doctor about it; I didn't do it because of the ads on TV or here. (CL, 75)

Importance of Issue

Direct-to-consumer pharmaceutical advertising has increased dramatically since 1997 when the FDA reduced restrictions on its use. In 2001 alone, almost $2.7 billion was spent on DTC advertising. Most of this advertising is concentrated on drugs for "lifestyle" conditions, such as hair loss, or chronic diseases such as arthritis and high cholesterol. Television viewers have learned to accept ads during the evening newscast promoting relief from ED, or erectile dysfunction, urinary incontinence, allergies, and toenail fungus. Over a remarkably brief period, consumers have been taught to identify by trade name and demand from their doctors a prescription for branded drugs. Consumers with arthritis and elevated cholesterol levels, for example, have learned to ask their doctor for Celebrex, instead of a nonsteroidal anti-inflammatory drug, and Zocor, rather than a statin.

Many physicians are complying with these patient drug requests. In 2000, increases in the sales of the 50 most heavily advertised drugs were responsible for almost

half of that year's increase in retail spending on prescription drugs. Debate within the medical community indicates mixed attitudes toward DTC advertising, with many physicians critical of the practice, reporting a perception that DTC advertising provides the patient with information that may not be clinically valid or even accurate. Other physicians appear to be more accepting of DTC advertising, even reporting that it has resulted in more informed patients. The majority of primary care physicians, however, report that with managed care plans limiting patient visits to an average 15 minutes per visit, doctors simply do not have time to fully discuss all the ramifications involved in various treatment options. Many doctors who might wish to discuss with patients all potential drug therapies are finding that in reality it is more efficient to just prescribe the brand the patient requests.

It is not surprising that much, if not most, DTC advertising is targeted to older adults. The incidence of chronic conditions increases dramatically as people age. Most individuals older than age 65 have one or more such conditions, including arthritis, hypertension, and cardiovascular disease, precisely the conditions for which the most heavily advertised drugs are designed to treat. New prescription therapies for previously untreated conditions like impotence, hair loss, and facial wrinkling also help fuel the rapidly increasing spending on prescription medications. Much of this proliferating DTC advertising is targeted to older women for several reasons: (a) older women live longer than men and thus are more numerous; (b) older women remain the key health gatekeepers for families, making medical appointments for spouses and, in general, making health care decisions; and (c) older women are more likely than men to discuss health-related issues with referent group members.

The rising costs of prescription drugs is a critical economic issue with increasingly important national implications. According to a recent AARP newsletter (Barry, 2002b), a current Medicare prescription benefit proposal costing $350 billion over a 10-year period would be "inadequate to fund what our members consider to be even a minimal benefit" (p. 2). Proposals to provide Medicare beneficiaries benefits equal to those provided members of Congress would cost $750 billion over a decade. While the two political parties currently propose varying plans, all recognize that the provision of adequate prescription drug benefits for the elderly increasingly will become a major political and health care issue. Because DTC advertising has been shown to be remarkably effective in increasing demand, especially for new and expensive "lifestyle" medications, its societal costs and benefits increasingly will be evaluated.

There has been very little academic research on the effects of DTC advertising. Information from marketing-oriented proprietary studies conducted by major pharmaceutical companies, their advertising agencies, and trade organizations, has not been placed in the public domain. For example, few studies have investigated the content of this advertising for qualities such as legibility (in print media), accuracy, and clarity of presentation of risk information. No studies were found attempting to gauge how consumers process and interpret the risk information presented in DTC ads or to measure consumer attitudes toward the images of disease states and the depiction of typical "sufferers" of the various diseases illustrated in DTC advertising. While studies have investigated the impact of DTC advertising on the patient/physician relationship, these studies have tended to examine the context of this relationship from the physician's point of view, with little or no investigation of the impact and meaning of DTC advertising for the target audience. For example, no studies have been found that have examined

whether increased advertising for treatments for conditions previously not considered a disease entity has increased either the target audiences' self-monitoring for disease or illness or their concerns relative to contracting these conditions.

The results of this study provide an insightful and useful understanding of how older individuals, especially women, perceive, interpret, and use this ubiquitous new form of advertising. Given the economic implications of increased drug costs, combined with the large and growing population of older adults, the present study provides useful knowledge to enlighten and guide future research into how consumers construct meaning for DTC advertising and integrate this advertising information into the context of their lives. The extension of the theoretical perspective guiding this study for research into additional areas of health communication will be evaluated. In addition, knowledge gained from this study will be evaluated for usefulness in two areas of application—(a) improved content and comprehension in DTC print advertising, and (b) changes at the national regulatory level to increase useful consumer information at less cost. These applications are discussed in the last section of this chapter.

Discussion of Findings

Exploring the context and meaning of DTC pharmaceutical advertising in the lives of consumers is important; it is a relatively new advertising phenomenon with serious health care and economic implications. At the same time, virtually no nonproprietary information is available on the meaning and effects of the advertising, despite increasingly large investments by pharmaceutical companies in virtually all media. The present study has attempted to increase understanding of how one group of consumers—older women—create meaning from and use this information in their interactions with their physicians and their referent group members.

It is interesting to note that in spite of a wide range of life experiences and ages—encompassing virtually two cohorts of women—almost all of the 45 women participating in this study had similar definitions of the concept of "good health." Regardless of age, marital status, and level of ability, the women were in accord in defining "health" in terms of freedom to participate in activities of their own choice. In addition, as women aged and developed increasing degrees of disability, they were able to adjust their expectations accordingly—a good night's sleep and a game of cards might become an activity of choice rather than golf or a brisk walk. The ability to redefine successfully the concept of "good health" into the context of diminishing abilities appears to be a significant marker of successful aging for the women in this study.

A second key area of agreement among almost the same number of women was their self-image as a "healthy" person. This image persisted in spite of obvious frailties and physical limitations. When asked to evaluate their personal health in comparison to the health of their referent group members, almost all of the women rated themselves from an "eight" to a "ten." The demographics of the study community may be one factor in these positive self-images. Many of the women lived in one of two large retirement communities; deaths and sudden disability due to falls, heart attacks, and stroke are a common occurrence in such communities. By comparison, study participants may feel themselves "very healthy" in the context of their social reality. However, another factor may be the presence of positive role models also living in such communities.

> I'm a ten in spite of arthritis and artificial knees and overweight. . . . One thing is I'm younger than a lot of my friends. . . . I don't think of that as all that young except around here, it's like wow, so many of my friends are 85 and they be-bop along and it amazes me. [C.L., 74, BV]

Research question 2 of this study queries whether and how elderly women use referent group norms in their evaluations of DTC advertising. The persistently positive self-evalations revealed by the women may be a reflection of group norms that urge women to minimize physical problems. This minimization, in turn, may be one factor behind the often conflicting statements women made regarding DTC advertising. If an older woman feels group pressure to discount her aches and pains, she may find herself hesitant to admit to attending to DTC advertising. On the other hand, the existence of such conditions may result in her recalling such advertising. "None are useful to me unless it's something that pertains to a symptom that I have." (W.G., 80, MO).

This study also found that the older women were more nuanced than the younger women in their measurement of the degree of closeness required in a relationship before they judged it appropriate to offer health-related information (research question 3). For example, while younger women appeared to be more comfortable in discussing information from DTC advertising with nonfamily acquaintances, older women often expressed a belief that such behavior was perhaps violating roles that they had long held important.

> I would suggest they go to their doctor. I just think that's the way to handle a situation if you're having a problem. [M.B., 81, MO]

The reluctance of older women to initiate discussions related to DTC advertising also may be due to the social context in which they live. Several of the older women mentioned the negative social feedback—shunning—attached to unwelcome health-related discussions. This practice may be related to an increasing difficulty in maintaining an intact self-image due to the obvious presence within their immediate environment of many infirm, ill contemporaries. Older women were quite explicit, in

fact, in describing the practice of shunning referent group members who ignored not-so-subtle messages to shift conversational topics from health to less threatening subjects.

The pervasiveness of television DTC advertising appears to be resented most by study participants. This may be because it is a more ubiquitous medium and thus provides a greater threat to maintaining their "healthy" self-image.[1] While DTC advertising proponents may claim that it provides a wealth of useful information, the unexpected effect of this information on the self-image of some consumer groups may need further exploration. If confirmed by other studies on broader population segments, advertisers need seriously to reevaluate the ultimate costs and benefits of DTC ad campaigns broadcast indiscriminately to large audiences.

This study found a key difference between the cohorts of women in their attitudes toward DTC advertising and the part it plays in their interaction with their physicians (research question 4). This difference partially refutes several of the characteristics of aging posed by activity theorists. For example, according to the activity perspective, old age roles and social situations facing older people are not clearly defined, and older people often face severe adjustment problems on leaving well-defined roles. This study found that the older women, especially, had decidedly explicit views about their roles as patients in the context of health-seeking behavior. The oldest group of women interviewed in this study strongly expressed a desire to retain a more traditional physician-patient relationship with clearly defined roles. They verbalized a clear understanding of their and their physicians' respective roles. The central message of

---

[1]This assumption was confirmed in the findings of a recent proprietary study which found that television drug commercials often repulsed viewers, and that viewers were "as likely to remember a drug's side effects as they are its benefits" (Dorschner, 2002).

DTC advertising—"Ask your physician for this drug"—was perceived to be a confounding message in the well-scripted role-playing that constitutes their expectation of a typical office visit. In addition, while many of the older women interviewed anticipated a negative reaction from their physician if they initiated a drug request, the younger group of women expressed fewer reservations about making such a request (research question 7). Thus, while the oldest group of women resisted the call for change in the patient-physician relationship that is embedded in DTC advertising, many of the younger women interviewed reported responding positively to such messages (research question 5). Finally, few of the women in this study reported any hesitance to discuss "stigmatized" conditions with their physicians (research question 6). In fact, several of the women in this study found such a question humorous. "If I found out I was pregnant in my old age, I'd ask him what to do" (B.J., 84, MO). Older and younger women alike acknowledged the usefulness of DTC advertising in removing the stigma previously attached to conditions like impotence and urinary incontinence. This finding has strong implications related to the ability of DTC advertising to convey useful information related to sensitive issues or conditions to targeted groups. These results need to be tested more widely, perhaps in pilot studies in target market areas.

Many women expressed conflicting opinions, within themselves and among each other, related to the usefulness of DTC advertising information (research question 8). While women of varying ages rated DTC information as positive and useful, in most instances this positive assessment was based on the relevance of the particular ad to their own or a close family member's personal health issues. Although more younger women than older women evaluated DTC advertising information as useful in their interactions with their doctor, many of the older women expressed a belief that such information

could be helpful. A subtle cohort difference existed between women who did not like DTC advertising. Younger women who negatively evaluated DTC advertising also often expressed a belief that DTC advertising was making a negative societal impact by manipulating increasingly large numbers of people into seeking medication for problems that otherwise might be solved through lifestyle changes. Older women who disapproved of the advertising often found the images and messages distasteful or inappropriate. Women from all age groups, but especially the older cohort, frequently expressed a belief that the required information on potential side effects was either frightening or unbelievable.

These findings suggest two separate and important modifications for DTC advertising. The first suggests that DTC advertising may gain legitimacy, in the opinion of target audiences, if it also provides information on lifestyle changes, such as diet and exercise, that if adopted may help relieve or lessen the condition the advertised drug is designed to treat. The second area of modification suggested by this finding is related to the current, regulatory-driven practice of including in a DTC ad every possible side effect manifestation, regardless of level of statistical occurrence. As written, this information may be so dire that it causes the target audience to ignore completely all side effect messages. Modifying this regulatory requirement to require the inclusion of warnings for only those side effects above certain statistical levels may actually increase attention to and comprehension of such messages.

DTC advertising copy comprehension and content assuredly have been tested at every level of production for all media. Today even minimally funded advertising campaigns are thoroughly concept- and copy-tested, first strategically before and during message creation and then from an evaluative perspective during and after delivery.

While this information is not available in the public domain, it is interesting to note that type size and legibility do present a significant problem for some older readers. The format for DTC magazine advertising typically includes at least two pages—a one or two-page layout with art and copy and a second (or third) page carrying the "brief summary" required by the FDA. [See Appendix H for samples of DTC advertising from the June issue of *Better Homes and Gardens* used as a prompt in this study.] Although a few women in this highly educated study population expressed difficulty with the medical vocabulary in the main page (as opposed to the "brief summary" page) of the ads, most appeared to understand the message, at least as far as the purpose of the advertised drug. It is significant, however, that many of the study population found that type size in the body copy, as opposed to the headlines and subheads, was difficult to read. It is most important to note that, of the 45 women participating in this study, not one voluntarily began reading the information on the "brief summary" page. When prompted, a few participants were observed attempting to read this page; most gave up, claiming that the type size was too small. ("I'd have to take a magnifying glass" [M.H., 80]) and the language only "fine print . . . for their legal protection" [C.L, 75, BV]. Even the youngest study participants claimed that the print size on the "brief summary" page was too small for comfortable reading. This finding has important implications for modifications related to type size and copy layout for DTC print advertising. It is especially important to note that many of the individuals in this study dismissed the inclusion of the "brief summary" page as a "mere legality." Based on these findings, this study suggests regulatory modification to eliminate the "brief summary" page, requiring instead the inclusion of essential information in type sized no smaller than 12 points within the body copy of the ad itself. While this regulatory change would almost

certainly reduce the amount of art work [see Appendix H], this loss would be justified by the overall gains in consumer information.

Limitations of Study

This constructivist study, based on the qualitative paradigm, makes no claims that the findings are generalizable to other populations. Moreover, the study population deliberately was limited to the upper end of the socioeconomic spectrum, as discussed in Chapter 3. It also should be noted that during the recruitment process described in Chapter 3, contacts refusing to participate in the study often gave one of three reasons for their refusal:

- Inconvenience (individual would be away on trip, was too busy with other activities).
- Poor health (individual had recently had surgery or illness and did not feel able to participate).
- When told that the purpose of the study was to obtain their opinion of some advertising, four individuals refused by saying that they "did not like advertising."

Therefore, it may be surmised that individuals who volunteered to participate in this study indeed may be (a) in better health than some of their referent group members, and (b) have a more positive attitude toward advertising in general than other members of the community. The themes that emerged from this analysis need to be assessed in light of these two assumptions. For example, if these relatively healthy and active participants had difficulty viewing the ads due to the small type size, it may be reasonable to surmise that there are other cohort members who may have even more pronounced visual difficulty with the small type. Likewise, since these participants were willing to be recruited to participate in a study of "advertising," other cohort members may exist whose opinions of pharmaceutical advertising are markedly more negative.

Directions for Future Research

Theoretical Implications

The usefulness of the qualitative paradigm in studying how people interpret and integrate health care information into their lives has been gaining increased acceptance. The depth and richness of understanding achieved through a constructivist perspective generates health research "that is rooted in a given respondent's set of circumstances, and health research that is related directly to and interconnected with, individuals' and group' beliefs and values about their own health and personal behavior" (Lincoln, 1992, p. 383). Specifically, the symbolic interactionist position used in this study provides an enriched understanding of the participants' construction of meaning of the textual elements of DTC advertising as well as a deeper understanding of the critical extra-textual factors such as perceived personal health, health beliefs, and social contexts that consumers bring to their encounters with pharmaceutical advertising.

The symbolic interactionist position, on which this study is grounded, is especially appropriate for this investigation because it accepts the reflexivity of social interaction, recognizing that each person's sense of self is constructed by a working sense of what is required for a particular place and time. While interactions with health care providers, especially for the women in older cohorts, are based on relatively structured roles, patients of all ages must create an individual response to DTC advertising directives to be more active in requesting pharmaceutical therapies from their physician. In addition, consumers must apply meaning to and incorporate DTC advertising into their interactions with referent group members. To be successful, group interactions depend on a mutual understanding of the symbols—in this case, DTC advertising. The social

reality of different referent group interactions provides a varying contextual framework into which information from DTC advertising must be incorporated.

This present study adds to the theory of symbolic interactionism and expands its usefulness in studying two key phenomenon. First, as recommended by Lindlof (1995), symbolic interactionism has not been "adequately explored" as a theoretical perspective for investigations of popular communication. This study is the first to apply this theoretical view to an analysis of the increasingly common phenomenon of DTC pharmaceutical advertising. As such, this study provides insight into more than merely the meanings participants applied to DTC messages; it explores how these messages are used within the context of the participants' lives. Second, this study extends the usefulness of the symbolic interactionist paradigm into investigations focused on the context of communication in health care interactions. Lincoln (1992), in an essay on the connections between qualitative methods and health care inquiry in the *Journal of Qualitative Research,* calls for "more research done in the places where human beings enact health practices: homes, schools, and work sites" (p. 389). Symbolic interactionism, with its emphasis on the contextual importance of the construction of social reality, provides a potentially powerful perspective for studying human health-related behavior. This theoretical perspective, when applied to other population groups, should provide additional information that would be helpful in fully accessing this advertising phenomenon. Extending this present inquiry to other socioeconomic groups also will help address the limitations of the current study as outlined above.

Few studies have examined other sources of health care information—both interpersonal and mediated—from the qualitative paradigm. For example, the symbolic interactionist perspective should be equally helpful in inquiries into consumers' behavior

with pharmacists, physician's assistants, and other health care personnel related to the interpretation and use of DTC advertising information. Although access to patient-physician interactions is difficult to obtain, as qualitative health research gains credibility in the scientific community, efforts should continue to construct and gain funding for studies to observe and analyze these interactions. In addition, studies examining how individuals of all ages interpret and integrate health-related information from new media sources, especially the Internet, into their social reality will be meaningful.

The implications suggested in this study of a subtle interaction between DTC advertising and older individuals' self-image also should be further investigated. The sheer volume of pharmaceutical advertising directed to this population group may carry a message of expected illness and frailty. The effect of DTC advertising on referent group interactions also warrants additional investigation. The explicitness of the shunning behavior for excessive health discourse uncovered in this study suggests that DTC advertising may produce unanticipated negative consequences for elders who take its suggestions too literally. In addition, the impact of the costs of increasing copayments for pharmaceutical prescriptions on retirees budgets already constricted due to shrinking retirement income needs to be monitored more closely.

Extending this research to include elderly males and other elderly members from other socioeconomic groups should provide additional insight into how older people interpret and use DTC advertising. Finally, additional studies need to be conducted with both men and women in the leading age of the "baby boom" generation—those individuals now entering their 50s. This current analysis revealed decided differences between the younger and older cohorts of elderly women. While the younger women in this study more frequently evaluated DTC advertising information as useful and they

reported more instances of making a request for an advertised drug from their physician, they also were more skeptical about advertising claims. Additional studies with this critical age group should provide information that will be helpful in evaluating this advertising in the future.

Implications for Changes in DTC Print Advertising

Information on how the women in this study reacted to and interpreted print DTC advertising should guide pharmaceutical companies and their advertising agencies in designing and constructing print advertising that is far more legible and comprehensible. The simplest and most obvious suggestion for change is to increase copy size throughout the ad, with no copy printed in less than 12-point type. Copy at all levels of an ad—headline, subheads, and body copy—should use clear, nonmedical language. The ads also should clearly state the condition the drug is designed to treat, success rates for the advertised drug, and potential nonpharmaceutical treatments such as diet and exercise. In addition, risk information, including possible side-effects and contraindications, should be stated clearly and simply, with the relative risks of treatment versus nontreatment spelled out.

The implications suggested in this study of a subtle interaction between DTC advertising and older individuals' self-image also should be further investigated. The sheer volume of pharmaceutical advertising directed to this population group may carry an unplanned message of illness expectation. The effect of DTC advertising on referent group interactions similarly calls for additional investigation. This study's discovery of very explicit shunning behavior for excessive health discourse suggests that DTC advertising may produce unanticipated negative consequences for elders who take its suggestions too literally. If confirmed by additional studies, these findings suggest

implications for changes in the tone and imagery of DTC advertising targeted to the elderly.

Regulatory Implications

The economics of DTC drug advertising need to be more carefully assessed. For example, each "brief summary" page in the issue of *Better Homes and Gardens* used as a stimulus for this study cost the advertiser approximately $245,000.[2] Increasingly, legislative proposals are being crafted to restrict DTC advertising expenditures. For example, proposals have been made to tie expenditures for DTC advertising to amounts spent on research and development. The present regulatory posture results in the expense of advertising dollars on the illegible, incomprehensible, and thus ignored pages of the "brief summary" information. This study demonstrates through direct observation and from the participants' remarks that these pages, as currently written and formatted, are perceived to be an unreadable "legality" and thus are discounted and ignored by the target audience. If this finding is confirmed by future studies, consumers may be better served through regulatory changes that allow the delivery of needed prescription information through more user-friendly channels. The research findings from this study need to be presented to the FDA both as a response to a Request for Comment and as a publication in an appropriate journal.

---

[2]According to figures from the Standard Rate and Data Service (2002) Consumer Magazine Advertising Source, *Better Homes & Gardens* standard rate for a one page black and white ad was $245,100; the rate for a four-color page was $279,600. The magazine issue used in this study contained 16 four-color pages of DTC advertising, 10 full black and white pages, and 4 one-third to one-half additional pages of mixed black and white and four-color DTC advertising. The DTC advertising from the June 2002 issue of *Better Homes & Gardens* is included as Appendix H. in this study.

APPENDIX A
RESEARCH QUESTIONS AND HYPOTHESIS

H1: Elderly people will have diverse interpretations of DTC pharmaceutical advertising because they have variable experiences and socialization related to health-related behavior.

R1: What do DTC pharmaceutical ads mean to elderly people?

R2: How do elderly women use referent group norms in their evaluation of DTC advertising?

R3: How do elderly women use DTC advertising as an information source when discussing health-related topics in their referent group interactions?

R4: How do elderly women incorporate DTC ad information in their interactions with their primary care physician?

R5: If elderly women feel these ads call for a change in their interactions with their physicians, how do they feel these ads effect such a change?

R6: How do elderly women feel about requesting a prescription for a drug for a stigmatized condition?

R7: How do elderly women expect their physician to respond to a request for a DTC advertised drug?

R8: How do elderly women evaluate the usefulness of DTC advertising?

APPENDIX B
INFORMED CONSENT FOR IN-DEPTH INTERVIEWS

Judith Jopling Sayre, a doctoral student in the Department of Advertising, College of Journalism and Mass Communications, is conducting a study on your views on direct-to-consumer (DTC) pharmaceutical advertising. This is the advertising suggesting that consumers ask their physician for a prescription for a particular drug. Ms. Sayre is researching how older women interpret and use DTC advertising.

This interview study is being supervised by Dr. Debbie Treise, Professor in the Department of Advertising, at the University of Florida, College of Journalism and Communications.

If you agree to participate in this interview session, all of your answers will be confidential to the extent provided by law. You will not be identified in any way. Ms. Sayre will not use your name or any identifying information to connect you with your answers. You do not have to answer any questions that you do not wish to answer. You may stop at any time without consequence. The interview session should take from 45 minutes to one and one-half hours. The interview will be audio-taped for transcription purposes only. The audiotape will be kept in a locked cabinet until it has been transcribed, and then it will be destroyed. Only Ms. Sayre and Dr. Treise will have access to the transcripts.

There are no anticipated risks and no direct benefits or compensation for participating in the interview, but your participation will be beneficial in helping the researcher understand your views about DTC advertising.

If you have any questions about this interview, Ms. Sayre can be reached at 904-280-0671. For additional information, Dr. Debbie Treise can be reached at 352-390-9755. If you have any questions about research participants' rights, you may call the University of Florida Institutional Review Board at 352 392-0433.

I have read the information provided above, and I have received a copy of this description. I voluntarily agree to participate in the interview as described. I understand that the session will be audiotaped.

Participants Signature _____ Date: _____

APPENDIX C
INTERVIEW DISCUSSION GUIDE

Let's talk about these ads.

1. First of all, what do you most remember about them?
   - **Prompt:** What did you think of the ads in general?
   - **Prompt:** What do you think of the imagery—the art work or photography?
   - **Prompt:** Was the print material in these ads easy or difficult to read?
   - **Prompt:** Did you find the language in the ads difficult or easy to understand?
   - **Prompt:** What do these ads mean to you?
   - **Prompt:** Do some of these ads seem more useful or helpful than others? [If so] Can you identify these ads and explain why you feel this way?

2. Are you familiar with other ads of this type?
   - **Prompt:** What does this general category of advertising mean to you?
   - **Prompt:** Can you name other ads of this type that you remember?
   - **Prompt:** Where have you seen the most of these ads?
   - **Prompt:** Are any of these ads for conditions or problems that you or a family member has now or has had in the past?

3. Have you ever discussed drug ads with friends or family members?
   - **Prompt:** What do your friends or family members think about these ads?
   - **Prompt:** Have your friends or family members ever discussed using information from drug advertising?
   - **Prompt:** When you discuss health problems with friends and family members, do you ever find information from drug ads useful?
   - **Prompt:** What kinds of information from DTC advertising is most helpful?
   - **Prompt:** How do friends or family members respond to suggestions related to an advertised drug?

4. How would you describe your relationship with your physician?
   - **Prompt:** Is your primary care physician the physician you talk to the most? [If not] What type of physician do you see the most?

5. How do you think your physician would respond to a request for a drug you saw advertised?
   - **Prompt:** How do you feel about asking your physician for an advertised drug?
   - **Prompt:** Have you ever asked your physician about a drug you saw advertised?
   - **Prompt:** [If yes] What was his or her response? [If no] What kinds of things would keep you from making such a request?

Prompt: Would you expect a different response to a request for an advertised drug from your primary care physician than from a subspecialist?

Prompt: Are there any conditions or symptoms for which you would hesitate requesting an advertised drug from your physician?
[If so] Why would you feel this way?

Prompt: Have your friends or family members ever discussed with you their physician's response to a request for an advertised drug?

6. Overall, how would you evaluate this form of advertising?
   Prompt: Why do you feel this way?

Let's talk about health in general.

7. How would you describe "good" health?

8. How would you rate the status of your own health?
   Prompt: How "healthy" are you in relation to your closest family members?
   Prompt: How do you rate your health in comparison with your friends?

9. Have any ads like these changed how you think about your own health?
   Prompt: Is there anything in these ads that makes you think of yourself or your health in a different way?
   Prompt: Has there ever been an occasion when a drug ad brought a symptom to your attention that otherwise you might have not noticed?

Thank you so much for your participation. Is there anything else you would add to this discussion that I may not have thought to ask?

APPENDIX D
INFORMED CONSENT FOR FOCUS GROUP INTERVIEWS

Judith Jopling Sayre, a doctoral student in the Department of Advertising, College of Journalism and Mass Communications, is conducting a study on your views on direct-to-consumer (DTC) pharmaceutical advertising. This is the advertising suggesting that consumers ask their physician for a prescription for a particular drug. Ms. Sayre is researching how older women interpret and use DTC advertising.

This focus group study is being supervised by Dr. Debbie Treise, Professor in the Department of Advertising, at the University of Florida, College of Journalism and Communications.

If you agree to participate all of your answers will be confidential to the extent provided by law. You will not be identified in any way. Ms. Sayre will not use your name or any identifying information to connect you with your answers. You do not have to answer any questions that you do not wish to answer. You may stop at any time without consequence. The focus group session should take approximately one hour. The interview will be audio-taped and videotaped for transcription purposes only. The audio tapes and video tapes will be kept in a locked cabinet until they have been transcribed, and then they will be destroyed. A number will identify you on the transcripts, and only Ms. Sayre and Dr. Treise will have access to the transcripts.

There are no anticipated risks and no direct benefits or compensation for participating in the interview, but your participation will be beneficial in helping the researcher understand your views about DTC advertising.

If you have any questions about this interview, Ms. Sayre can be reached at 904 280-0671. For additional information, Dr. Debbie Treise can be reached at 352 390-9755. If you have any questions about research participants' rights, you may call the University of Florida Institutional Review Board at 352 392-0433.

I have read the information provided above, and I have received a copy of this description. I voluntarily agree to participate in the focus group as described. I understand that the session will be audio taped and video taped.

Participants Signature _____ Date: _____

APPENDIX E
FOCUS GROUP GUIDE

First of all, I thank you for coming here today and being willing to talk with me about these ads.

Let's talk about these ads.

1. First of all, what do you most remember about them?
   - **Prompt:** What did you think of the ads in general?
   - **Prompt:** What do you think of the imagery—the art work or photography?
   - **Prompt:** Was the print material in these ads easy or difficult to read?
   - **Prompt:** Did you find the language in the ads difficult or easy to understand?
   - **Prompt:** What about the information related to side effects or symptoms? How difficult or easy to understand was this information?
   - **Prompt:** What do these ads mean to you?
   - **Prompt:** Do some of these ads seem more useful or helpful than others? [If so] Can you identify these ads and explain why you feel this way?

2. Are you familiar with other ads of this type?
   - **Prompt:** What does this general category of advertising mean to you?
   - **Prompt:** Can you name other ads of this type that you remember?
   - **Prompt:** Where have you seen the most of these ads?
   - **Prompt:** Are any of these ads for conditions or problems that you or a family member has now or has had in the past?

3. Have you ever discussed drug ads with friends or family members?
   - **Prompt:** What do your friends or family members think about these ads?
   - **Prompt:** Have your friends or family members ever discussed using information from drug advertising?
   - **Prompt:** When you discuss health problems with friends and family members, do you ever find information from drug ads useful?
   - **Prompt:** What kinds of information from drug advertising is most helpful?
   - **Prompt:** How do friends or family members respond to suggestions related to an advertised drug?

4. Have any ads like these changed how you think about your own health?
   - **Prompt:** Is there anything in these ads that makes you think of yourself in a different way?
   - **Prompt:** Has there ever been an occasion when a DTC ad brought a symptom to your attention that otherwise you might have not noticed?

I'd like to ask you some questions about your health and your relationship with your physician. Of course, you don't have to give any specific health information that you don't want to disclose, and you won't be asked to disclose the name of your physician.

5. How would you describe your relationship with your physician?
   Prompt: Is your primary care physician the physician you talk to the most?
   [If not] What type of physician do you see the most?

6. How do you think your physician would respond to a request for a drug you saw advertised?
   Prompt: How do you feel about asking your physician for an advertised drug?
   Prompt: Have you ever asked your physician about a drug you saw advertised?
   Prompt: [If yes] What was his or her response?
   [If no] What kinds of things would keep you from making such a request?
   Prompt: Would you expect a different response to a request for an advertised drug from your primary care physician than from a subspecialist?
   Prompt: Are there any conditions or symptoms for which you would hesitate requesting an advertised drug from your physician?
   [If so] Why would you feel this way?
   Prompt: Have your friends or family members ever discussed with you their physician's response to a request for an advertised drug?

Let's talk about health in general.

7. How would you describe or define "good" health?
   Prompt: How "healthy" are you in relation to your closest family members?
   Prompt: How do you rate your health in comparison with your friends?

8. Have any ads like these changed how you think about your own health?
   Prompt: Is there anything in these ads that makes you think of yourself or your health in a different way?
   Prompt: Has there ever been an occasion when a drug ad brought a symptom to your attention that otherwise you might have not noticed?

9. Overall, how would you evaluate this form of advertising?
   Prompt: Why do you feel this way?

10. Do you have any comments about this form of advertising, about health issues, or about patient-physician relationships that you'd like to add to this discussion?

Thank you so much for your time and your participation in this group discussion.

APPENDIX F
SAMPLE INTERVIEW TRANSCRIPT

Interview with E.F. - 5/28/02

WHAT DID YOU SAY ABOUT ADVERTISING?
I feel that advertising in magazines such as this and newspapers and on TV is definitely one of the reasons that drugs and medications and prescriptions are so expensive and keep becoming more expensive. I think doctors should know what this advertising is trying to tell us.

DO YOU GET THIS MAGAZINE?
No, I don't. The only magazine my son gives me is Money. We have access to everything here. Magazines, books, newspapers. Am I missing anything?

THERE IS ONE ON PAGE 83.
I've never heard of this one. Altace. I've never heard the name. It's a nice magazine. It's the kind I look at when I'm at the hairdresser, for instance, or waiting somewhere.

WHAT ABOUT PAGE 105?
Lipitor. Is that the one? That I'm familiar with. This is something, I believe, that you take if you've already had a minor heart attack. Is that the way you understand it? I have a problem with cholesterol, but this has never been suggested for me. I'm on another prescription for cholesterol. I always thought Lipitor was for somebody who already had heart trouble or one of the things they promote for heartburn. You can't eat hot dogs or sausage or anything that's not good for you. All you do is take a pill for heartburn. I think that's dreadful. You should be told don't eat the things that give you heartburn. I'm sorry. I don't go for it. Aren't you familiar with those on TV? They're on all the time constantly.

HAVE YOU SEEN THAT ONE BEFORE?
That's on the TV all the time. The purple pill. I don't know what it's called. I have arthritis of the muscle. It's called polymyalgia. It's very rare apparently. It's arthritis of the muscle from the waist up. It started with me 13 years ago. The only thing that helps it is Prednazone, which is a steroid. I feel nothing now. I take one a day with breakfast. The doctor tried eliminating this by degrees. Two days without it and I was right back where I started. You can't give that drug up. Fortunately I take a small dosage. I don't feel a thing. It runs in my family. There has never been any cancer. It doesn't mean I couldn't have it or my children, but it does help. I've never had a mammogram. I've never had a colonoscopy and I don't intend to. If they found anything I wouldn't go

through chemo anyway. Not at my age. I've never had the flu and I've never taken the flu shot. I'm not inclined to cold, sinus, coughing. I don't get colds.

WHICH ADS DO YOU REMEMBER THE MOST?
That Nexium I think just because I've seen it so many times. Lipitor. There are a lot of people here who take it, including my beloved son. The average age here is about 80. When I signed up it was closer to 75 or 76. We're all living longer. Many are as strong and active now as they used to be at 75.

WHAT DO YOU THINK OF THESE ADS IN GENERAL?
It happens that none of the ones we saw in here pertains to any problem I have. I don't pay attention to them. This is the time I get a glass of water. If I'm watching TV and this stuff comes on, I'll leave it.

DO YOU THINK THE APPEAL IS THE IMAGERY OR THE MESSAGE?
I guess on TV it's the imagery.

DO YOU THINK THE PRINT IS EASY OR DIFFICULT TO READ?
I think it's relatively simple, easy for the average person. I don't think it's too difficult.

WHAT ABOUT THE TYPE SIZE?
That could be difficult. This is the only time I need glasses is to read this sort of thing and to write. Otherwise I don't play bridge with glasses. I don't drive with glasses. I could read this if I had to. I can't read this without my glasses and my eyes aren't bad.

DID YOU READ ANY OF THE WARNING INFORMATION?
No. That was only because ***(inaudible)*** medications didn't have anything to do with me. I look at this and just flip the page or flip the TV or leave the room for a minute. I don't mean I'm totally anti. It just doesn't affect me.

DO YOU THINK THERE ARE RISKS ASSOCIATED WITH TAKING THESE DRUGS?
Oh, I think there is a risk with any and every. It always tells you the possible side effects. They have to.

DO YOU THINK THESE RISKS ARE SERIOUS?
They could be. That would depend upon the patient. How many other drugs the patient is taking, the age of the patient, how serious their problem is as to why they're taking this drug. There are so many things about whether or not a drug is dangerous. It's dependent upon a lot of facts.

ARE YOU FAMILIAR WITH OTHER ADS OF THIS TYPE THAT MIGHT NOT HAVE BEEN IN THIS PARTICULAR ISSUE OF THIS MAGAZINE?
There's the one for diarrhea and there's one for the opposite of diarrhea. Aspirin is advertised quite a bit. I see aspirin on TV.

YOU MENTIONED YOU TAKE PREDNAZONE AND YOU DON'T SEE ADS FOR THAT. YOU MENTIONED YOUR SON HAS HEART TROUBLE AND TAKES LIPITOR. DO YOU EVER NOTICE THE ADS FOR DRUGS FOR CONDITIONS THAT A FAMILY MEMBER OR FRIEND MIGHT BE TAKING?
Lipitor is very popular here. It's one of the most used drugs, I think.

HAVE YOU DISCUSSED ANY OF THESE ADS WITH FRIENDS OR FAMILY MEMBERS?
No, we don't. We try not to. Everybody here has some kind of problem. I would be the exception. If we sat around and everybody talking about their health problem and what drugs they take and which doctor they go to we'd be a nightmare. It wouldn't be any fun at all.

DO THEY EVER TALK ABOUT THESE ADS?
No. Not to me.

WHEN YOU ARE THINKING ABOUT HEALTH PROBLEMS AND TALKING WITH SOMEONE ABOUT A HEALTH ISSUE, DO THEY EVER SAY THEY GOT INFORMATION FROM AN AD?
No.

IS THERE ANY KIND OF INFORMATION THAT THIS ADVERTISING DOES HAVE THAT YOU FEEL LIKE IS HELPFUL?
Not to me. I wouldn't be interested in a drug or anyone of these things in here. None of these I take. I would have to talk to my doctor.

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH YOUR PHYSICIAN?
I'm very happy. Very happy. He does have a pleasant bedside manner, which is not the most important thing with a doctor but it does help.

IS THIS YOUR PRIMARY CARE PHYSICIAN?
Yes.

IS THAT THE PHYSICIAN YOU TALK TO THE MOST?
You don't talk to him. You talk to a nurse. That's something I'm aware of now. You never talk to the doctor unless you're visiting on appointment. Not on the phone.

WHEN YOU'RE VISITING IS THIS PERSON RESPONSIVE?
Yes.

WOULD YOU FEEL COMFORTABLE ASKING YOUR PHYSICIAN FOR A DRUG THAT YOU SAW ADVERTISED?
I might. I was the one who asked him is it ever possible for me to give up the drug or is there another drug that takes its place. He said absolutely not. To their knowledge there is no drug that takes its place. Side effects from Prednazone can be bad. I am fortunate and I take such a small quantity that I've never had side effects.

WOULD YOU FEEL COMFORTABLE?
I might. I've been very close to my son since this emergency surgery. He's shared some drugs with me. Yes, I might ask about something. I don't think I have.

YOU CAN'T TELL ME WHAT YOUR PHYSICIAN'S RESPONSE WAS LIKE?
No. I've had one or two drugs I've had to give up. The side effects were such that I would tell the doctor and I quit the drug.

CAN YOU THINK OF ANY CONDITIONS YOU MIGHT HAVE WHERE YOU WOULD SIMPLY HESITATE REQUESTING AN ADVERTISED DRUG FROM YOUR DOCTOR?
I don't think so. I don't have anything now.

HAVE YOU EVER HEARD ANY FRIENDS OR FAMILY MEMBERS DISCUSS THEIR PHYSICIAN'S RESPONSE WHEN THEY ASKED FOR AN ADVERTISED DRUG?
No. I don't see that much of my children to get into that.

DESCRIBE GOOD HEALTH.
Proper weight. Too many people are overweight. Lack of activity is part of our problem. Bright eyes with sparkles in them. The better one's skin looks the healthier. Posture. Walk decently. No limping. That leaves an impression. Your posture, your eyes, hair.

HOW WOULD YOU RATE THE STATUS OF YOUR OWN HEALTH?
I have one thing that's very dangerous. ***(Inaudible)*** in my legs. All they've been able to do so far is ***(inaudible)***. I had an emergency operation four weeks after I got injured. That wasn't the first one. The original operation was in 1985. I'm not taking a drug for it. I'm taking a drug to help prevent blood clots. That's pretty good. This is pinkish and warm. If this starts to get blue it's lack of circulation. I had a dreadful cut here very recently. I was two and a half months in bandages and ***(inaudible)***. No walking. This is all from the Prednazone. You touch me and I'll hit the ceiling. If anything touches me any harder, I cut and I bleed.

EVEN WITH THIS YOU SEEM TO BE GETTING AROUND PRETTY WELL.
I have to. I walked a mile this morning. I'm just back to a mile a day. I couldn't go outside. I had a golf sock someone gave me and I put a bag over that. I wasn't exercising for two and a half months. I went around and made my bed and got my bills together. I wasn't in bed. This leg isn't quite as bad. That's the only thing I have.

HOW WOULD YOU RATE YOURSELF IN RELATION TO SOME OF YOUR CLOSEST FRIENDS?
It all depends on what you think is the biggest handicap. People fall. That happens frequently. Lack of balance. Or just a minor heart attack. They break a hip, an arm, a knee. Knee things they seem to replace. This happens frequently. We all die in the end from a heart that gives out. You can have other things but when your heart stops beating you pass away. It doesn't necessarily mean you die from a heart condition. Which physical ailment you have to you may be the most severe one. I'm very concerned about what I have. I have a neighbor who has rheumatoid arthritis. The pain and the drugs.

There are people here who don't exercise at all or even get the mail. I do a lot of housekeeping. I change my own bedsheets. The maid will do it and most people here let the maid. I do it for exercise.

IN SPITE OF THE FACT THAT YOUR FRIENDS HAVE MULTIPLE HEALTH PROBLEMS HEALTH TOPICS DON'T TEND TO BE THE MAIN TOPIC OF CONVERSATION?
Absolutely right. If you find people who talk too much about their health we don't see them. We don't invite them to join us. You know who they are. That's how it happens. It becomes a bore.

MOST OF YOU SOUND LIKE YOU'RE FAIRLY WELL INFORMED ABOUT YOUR HEALTH.
I think so.

WHAT SOURCES OF INFORMATION ARE MOST IMPORTANT TO YOU OTHER THAN YOUR PHYSICIAN?
Maybe reading. You can read articles on health and take it whichever way you want to or however it takes you. I don't talk to people about it. There are hardly any two people here who really have the same physical problems. There is a lot of arthritis but one has had it for ten years and the other is just beginning to get it. One has it in her legs and the other one in her hands. They're even taking different drugs for it. Let alone the heart conditions. We have people wearing hearing aids. They work very well for some people but they're not for everyone.

YOU HAVE TWO CHILDREN. ONE LIVES IN SAN FRANCISCO AND ONE LIVES IN WASHINGTON. YOU'VE LIVED HERE FIVE YEARS.
Uh-huh. The children are a son and daughter.

ARE YOU A WIDOW?
24 years.

WHERE DID YOU LIVE BEFORE?
Connecticut. Within commuting distance of New York. My husband worked in New York City.

WHAT WAS THE LAST YEAR OF SCHOOL YOU COMPLETED?
High school.

DID YOU EVER WORK OUTSIDE THE HOME?
Yes. After I graduated from high school I worked at Franklin Simon. That's a department store that has long since been out of business.

WHAT IS YOUR BIRTHDAY?
April 2, 1918.

THANK YOU.

APPENDIX G
ST JAMES FOCUS GROUP
7/25/02

(TAPE STARTS ABRUPTLY. CONVERSATION IS UNDERWAY ABOUT HRT)

WELL, HOW MANY AROUND THIS TABLE TAKE HRT—OR USED TO TAKE IT?
["I used to." (One respondent agreed.)
(Five respondents take HRT.)
[S.S.] "I'm actually on Prempro. From the very beginning it's been do I, do I not, do I? The information has been so controversial. It didn't matter what you decided something was wrong. But that last study has made me start thinking maybe I'll try weaning myself off it for just a little while, about two or three months or so, and see if I really know. But, the bone thing."

[M.A.M.] "The doctors, you talk about it being pushed. The doctors and I guess the drug companies pushing it to the doctors. But I switched physicians four times at one point just switching back and forth, should I take it or not, and every one of them came on so strong. Oh, you must have it, you have to have it. What it does for your bones and your blood pressure, your heart, and all that. I said what about my little tumors in my breasts, and my little bad pap smears? It turns out with me that's exactly what was causing that. I had to take myself off; they wouldn't. But my mammogram guy he said, when I went in four months later he said what was the intervention. I said, I took myself off estrogen. He said, well that was the culprit. But they push it."

[M.R.] "My daughter is a nurse/midwife. She's married to an OB/GYN. She's had to be on Premarin for years. She really really believes in it. I took myself off of it because I gained weight and I felt bloated. I said, uh-huh, no more. Well, she cut down on it. When I remember it, I take it."

SO HAS HRT BEEN A PRODUCT YOU'VE NOTICED BEFORE IN ADS?
"Oh, yes." (Several respondents agreed.)
[N.M.]"This Pat Labelle has been on TV a lot."
[L.B.]"The model, Lauren Hutton." (One respondent agreed.)

(MODERATOR ASKS RESPONDENTS TO LOOK AT THE AD.)

WHAT WOULD GET YOUR ATTENTION ON THIS AD?
[M.R] "Patty."

[M.A.M.] "Well, they look so good. That's what they've chosen, a woman that you know that is a little older. Boy, does she look great. She looks young. Her skin looks nice and smooth and shiny."
[M.M.] "She looks happy."
[S.S.]"Looks like she feels good."

[N.M.]"I think the HRT too. Because I think everybody kind of tuned into that now." (One respondent agreed.)
[M.R.]"Because of that."

DO YOU THINK PEOPLE ARE PAYING MORE ATTENTION BECAUSE OF THE NEWS?
[L.B.]"No, I think that before this bad news came out woman were paying more attention about HRT because there are articles on it all the time."
[M.A.M.]"Most of them are positive, don't you think?" (One respondent agreed.)
[L.B.]"I think until this last business that came out."
[M.M.]"It's a preservation type thing." (One respondent agreed.)
[M.R.]"All the history, my parents have scoliosis or the curvature of the spine. I have a daughter who is 38 degrees scoliosis. My poor daughter is watching her P's and Q's because my mother- in-law and my mother had osteoporosis. With the scoliosis it's something they really want to look at."

IS THE FACT THAT IT'S PATTY LABELLE THAT WOULD GET YOUR ATTENTION?
[L.B.]"I don't even know Patty Labelle. It's just her."
[M.R.]"And how good she looks."
[M.M.]"Not who she is, but what she looks like."
[S.S.]"She could have been any good looking older mature." (Several respondents agreed.)

WHAT ABOUT THE LANGUAGE IN THIS AD?
[M.A.M.] "I'd say yes to HRT." (Several respondents agreed.)
[M.M.]"That's a big right up here at the top, menopause."
"Menopause?"
[S.S.]"I'd say yes."
[M.R.]"That to me was very enticing. I said yes, it doesn't matter what it's to."
[N.M.] "It's like a team let's get together here."

WHAT IS YOUR EVALUATION OF THE LANGUAGE? IS IT EASY TO READ?
[L.B.] "Very." (One respondent agreed.)

IS THE PRINT EASY OR DIFFICULT TO READ?
[M.R.] "I like the different colors." (Several respondents agreed.)
[N.M.] "You pick that up right away."
[L.B..]"When you read the symptoms, they're the symptoms of everything."

[S.S.] "Also, even the small print is larger than the other than the others you would normally see. The age group that they're reaching makes a big difference because almost all of us have to wear glasses."
[M.A.M.] "Good point."
[M.M.] "Until you get down here."
[L.B.]"Even the small print is not small on the back."
[M.M.]"Oh, yeah. Isn't that the truth?"
[N.M.]"Look at the whole page."
[S.S.]"They have some side affects listed on the front."

LET'S TALK ABOUT THE BACK. IS THIS A PART OF AN AD THAT YOU'VE EVER READ BEFORE?
"Unh-huh." [several agreed]
[N.M.]"Not really."
[M.M.]"I skip that."
[M.R.]"Some, just because I was very ambiguous. I didn't know really whether I wanted to follow my daughter's advice or follow what my body was telling me. So I did read this. It scared me because of the uses of estrogen. This may not apply. I'll talk real fast. But, I was in a study, a line ended study on estrogen, estrogen with Progesterone, and the sugar pill. Even the doctor didn't know. Well, unfortunately I got just the estrogen, which is very bad for people who are complete. I had quite a bad reaction. This was a year. It was just the estrogen. It was not good for my body. But, anyway that's why I read just because my experience."

ON WHAT YOU NORMALLY, HOW DO YOU EVALUATE THE RISK?
[L.B.]"I always read the contraindications and the side affects. Even with prescription drugs, I read that. I always read the side affects or the contraindications." (One respondent agreed.)

WHERE DO YOU READ THAT USUALLY?
[L.B.] "Well, when you get the prescription they give you a printout now. It gives you that information. With this, that was one of the first things I read here." (Several respondents agreed.)
[M.A.M.]"I have to now." (One respondent agreed.)
[N.M.]"Is this for their own protection do you think that they put that in there?"
[S.S.]"A lot of drugs interact with each other."
[moderator]"It's required by the FDA. If you look at a lot of the television ads refer you back to a print ad, or to a 1-800 number, or to a web site. That's a requirement."
[S.S.]"They will say the side affects, and they say them so quickly that you have to listen very intensely to understand them."

DO YOU THINK THERE IS A RISK ASSOCIATED WITH TAKING MOST OF THESE KINDS OF DRUGS?
[S.S.] "Absolutely." (Several respondents agreed.)
[M.R.]"I had been on just the plain estrogen for years and years."
[M.M.]"Have you had a hysterectomy?"
[M.R.] "Uh-huh."

[[M.A.M.] "If you've had a hysterectomy, then that's okay. I haven't. It really makes it kind of weird because you don't know what to do. That's one of the things they're saying about the Prempro. Because it has progesterone in there, and that's one of the things."
[M.A.M.]"But that's what they say you need. You shouldn't take estrogen alone."
[S.S.]"If you have a uterus you have to have estrogen and progesterone. But apparently this study was on this one because it had both, and apparently the Premarin that was pure estrogen they did not stop that study; they continued that study. Which says to me it was something to do with the progesterone that was causing."
[M.M.] "You know Mary[Xxx]? She had a hysterectomy years ago and they left her ovaries. She's got ovarian cancer, like stage four ovarian cancer. You're thinking to her this is a woman that is really before this cancer thing was just about the sharpest looking older woman around. She said to me, you know, why didn't they just take the ovaries? What was I going to do with those ovaries?"
[S.S.] "But I had a neighbor; her husband was actually a physician. Her mother died of ovarian cancer. She had had a hysterectomy. She went to her physician and said can I have my ovaries removed? They wouldn't do it. So, you never know. But, anyway that's another problem."

(MODERATOR ASKS RESPONDENTS TO LOOK AT SOME OTHER ADS.)

IS THIS AN AD THAT YOU WOULD NOTICE?
[L.B.]"I would notice it because I have migraines." (One respondent agreed.)
[N.M.]"I have had them in the past. I might for that reason."

WHAT MAKES YOU NOTICE AN AD?
[M.R.] "I think the verbiage in this because it was difficult to decide if this was a nurse or the mother. I remember seeing the ad, and the verbiage kind of was enticing because to me it looked like a nurse as well."

(MODERATOR SHOWS RESPONDENTS A SPLIT FORMAT AD.)

WOULD YOU HAVE NOTICED THAT?
"No." (Several respondents agreed.)
[M.R.] "As a matter of fact, I get it now. But what I saw here, and it was like what does this mean that she had a migraine? What is looking at this baby have anything to do with having a migraine?"
[S.S.]"I personally think this is a little cluttered. You've got these two people up here that don't seem to go with this lady here."
[N.M.]"It goes with migraine."
[L.B.]"I've got to tell you, my feelings is if you have migraines and some new drug has come out, no matter how bad the ad was you would pay attention because migraine sufferers are desperate."
[L.B.]"My assistant had migraines terribly. I think I became sensitive because of her." (One respondent agreed.)

[M.M.]"I had fever blisters. If an ad came out and said this is the new great care for herpes, I got to tell you I don't care how bad it was, I would read every tiny little word because that is my particular problem is the cold sore, whatever you want to call them."

IS THE FACT THAT IT RELATES TO SOMETHING THAT YOU'RE HAVING A PROBLEM WITH A KEY FACTOR?
[S.S.] "Absolutely." (Several respondents agreed.)

DO YOU FEEL LIKE YOU'D NOTICE AN AD FOR SOMEONE ELSE?
"Uh-huh." (One respondent agreed.)
[M.R.] "Children, grandchildren." (One respondent agreed.)
[N.M.]"Someone you care about."

WHAT ABOUT FRIENDS?
"Yeah." (Several respondents agreed.)

HAVE YOU TOLD A FRIEND ABOUT SOMETHING YOU SAW IN AN AD?
[S.S.]"Well, I don't know whether it's because I saw it in the ad. Obviously after my husband's situation and somebody says to me well I've got acid reflux, it's no big deal. I said hey, it's a big deal. You pay attention to it. Things that I never paid attention to before, and I do pay more attention to Nexium ads and Prilosec, generic drugs, stuff like that. But that's because of my particular situation. It doesn't necessarily mean it's because it's an ad."

IF YOU HAD A FRIEND OR A FAMILY MEMBER WHO HAD A CONDITION AND YOU SAW AN AD FOR THIS CONDITION, HOW LIKELY WOULD YOU BE TO TELL THEM ABOUT IT?
[M.M.]"I would tell them."
[L.B.]"I would check it out."
[N.M.] "Since I have migraines and I know other people that do have migraines, since we have a common interest, I would probably be more likely to tell the person."
[M.A.M.]"Or ask them if they have tried it." (Several respondents agreed.)
[M.A.M]"Or if they knew about it."

DO YOU REMEMBER AN INSTANCE WHEN YOU DID THAT AND THE RESPONSE YOU GOT?
[N.M.]"It happened with this Imitrex when I was working. Another in my woman in my office had migraines too. She was taking that. I asked her about it."
[L.B.]"I've done that with my assistant. I would ask her has this been prescribed for you, or have you heard of this. Because like [M.A.M.] said, you're just desperate to try anything that would work. She would get so ill." (Several respondents agreed.)

IN CONVERSATIONS WITH FAMILY MEMBERS OR FRIENDS, HAS ANYONE EVER COMMENTED TO YOU ON DIRECT TO CONSUMER ADVERTISING?
[L.B.]"Only in the context, and I firmly believe this, that with the advertising that we see on television now we have been taught to take the medication for every ailment that

comes along. If we have a headache we rush to the medicine cabinet. If our toe aches we go look for something for that. I think through advertising this is a concept that had been taught to us and our children and the next generation down. Certainly my parents never had this concept." (One respondent agreed.)
[M.M.]"Oh, Lord, mine did."
[S.S.]"I don't take more than five aspirins a year, if that many."
[L.B.]"But, don't you get this feeling? It's with the dancing feeling with the Viagra. If you take this, wow you look like Patty Labelle, you go out and dance all night."
[S.S.]"I heard something just recently. They were saying that new drugs coming out from the FDA, that a substantial percentage of them in the last so many years have not been necessarily to cure anything, but to improve lifestyle in some way. That's what you're getting on the TV. Viagra you're going to feel better and do this stuff. HRT you're going to stand taller and straighter and stuff."
[L.B.]"Your boobs are going to look better."
[S.S.]"That Datrol or whatever, your urinary problems are going to go away."
[L.B.]"That's what I'm saying, we've been taught."
"It's all like a lifestyle."
[M.A.M.]"And Celebrex, takes all the pain away."
"It's deadly on your stomach."
[S.S.]"Everything is going to be fun if we do this." (One respondent agreed.)
[M.A.M.]"We have been taught, and we have been given the impression that this magic potion is going to make us younger and more appealing."
[M.R.]"But then after they say all these wonderful things, then they spend this time saying if you take this it doesn't do that, you may not be able to do this."
[S.S.]"This is what they say, the most common side affect of Nexium and Prilosec are headaches, diarrhea, and abdominal pain. Symptom relief does not rule out serious stomach condition."
[M.R.]"Which is why you're taking it to begin with."
[S.S.]"However, this is actually the one that for those that really need it, the Prilosec taken earlier my husband may not have had esophageal cancer. That's one of the fastest; I think it's like a 400% increase in esophageal cancer over the last so many years. So it's really hard. But I agree with you on the same thing. Prior to this incidence in my life I would have said who wants to that. But it is a serious thing. I want you to know it is a serious thing." (One respondent agreed.)

ARE THERE TIMES WHEN AN AD MAY BRING A SYMPTOM TO YOUR ATTENTION?
[M.M.]"Oh, absolutely. Depression, I didn't know I was depressed until I read about it." (Several respondents agreed.)
[[M.M.]"It's not going to save your life, but it's going to make you feel better. I got to tell you, it works. I don't care."
[L.B.]"The quality of life again. It could be a placebo and it would help me." (One respondent agreed.)

DO WE SEE CANCER DRUGS ADVERTISED?
[S.S.]"No, with exception, which this is a lifestyle. You do see the Procrit, which means that the cancer patient can function. So it's still the lifestyle."

[S.S.]"Even though it's a serious cancer drug, believe me my husband worked in XXXXX sales for well over 20 years. Epoetin which Procrit, is the same type thing, for kidney patients improved their lifestyle so much you wouldn't believe. But you don't see Efigen. How many kidney patients are there? You don't see that. But the Procrit maybe because it's J&J. They're not once saying in those ads that those people are going to get cured from cancer, or that it's going to help their cancer in any, way, shape or form. But they're going to be able to do something with the grandchildren, and it does do that. But it's still a lifestyle change."

[L.B.]"I think a lot of these things that are being advertised now are definitely in the closet, like the Viagra. That certainly wasn't a conversation that you would have with mixed company or anything like that. Depression, all these things are things that are just now being out in the open. The same thing with the one about the lady, I got to go, I got to go, the bladder problem." (Several respondents agreed.)

LET'S TALK ABOUT THIS DATROL AD.

[M.R.]"What is that?"

[S.S.]"That's got to go, that's got to go."

DO YOU EVER REMEMBER YOUR GRANDMOTHER OR SOMEONE ELSE WITH THIS PROBLEM?

"I do."

[M.R.]"I can remember mine having some trouble. It was so common with older women."

[M.A.M.]"It's extremely common at the clinic. It was something we worked with every day. Patients that you could pick the odor up."

HOW DO YOU EVALUATE ADS FOR A CONDITION LIKE THIS? DO YOU THINK IT'S A POSITIVE THING?

"I think so." (Several respondents agreed.)

[M.M.]"I only have a few words. My words are better living through chemistry. Anything that makes me feel better, even if there is a degree of risk, I'm willing to take risk. I smoked for 30 years, I'm no sissy."

[L.B.]"Well, I'm old and can be a sissy."

[M.A.M.]"I really am just the opposite. I've never been sick. I've never had much wrong with me. I do not like medicine. I will not take it. If I have a bad headache I will take a Tylenol. I think we have just gotten to the point where it's like a crutch. I know it makes us feel better." (One respondent agreed.)

"Temporarily."

[N.M.]"I was in biofeedback for years. We did the mind thing; working on these things, mind over matter kind of stuff. So I lean more that direction." (One respondent agreed.)

[M.R.]"I think if somebody has pain though, oh yes if I was in pain I'd be taking a pill."

[S.S.]"You have to weigh the risks. I just don't take something. As far as I'm concerned how bad is this problem, is it going to affect me forever, this problem forever, and what is the side affects going to do to something else? If I take this drug am I going to not have to go to the potty, but then might have a heart attack? That kind of thing. I pay pretty close attention to it. I don't just take the drugs."

[M.A.M.]"Now my daughter is a nurse, and she has drugs all over the house. Then she sends the children for me to keep, and says do you have this. I'll no, I don't, just send it if they must have it."
[M.M.]"I think younger people are far more into it." (Several respondents agreed.)
[N.M.]"Because I'm very careful. I don't think you should mix things. I know people that just pop that, and then they pop that. I say oh my gosh."
[M.A.M.]"Then they get one from a friend." (One respondent agreed.)
[S.S.]"That's the one that gets me. I can't imagine anybody just taking a prescription drug from a friend."
[N.M.]"There are people that just take pills to go to sleep. They take something to wake up, and that kind of thing. No, I don't believe in that at all."
[S.S.]"I don't either, but I do go along with M.M. with the quality of life and the Procrit. I think it's a godsend to anyone who has ever been through that."
"As a matter of fact, when my husband was going through chemotherapy because he was on dialysis for a long period of time, he actually asked for Epo(?). He asked his oncologist, he says I know what Epo(?) does, I've been selling blood lab for 20 years, and I know what this does. Well, no I don't know that you need it or whatever. He didn't get it, but he was about ready to go to the dialysis unit. I probably shouldn't tell this. There was a guy that said I could save you some at the end of every little vial and give you some if you just really need it. He was about this close to doing that. But he was not someone that didn't know a lot about that particular drug. That's what the big difference is."
[L.B.]"But this is a topic you brought in earlier, that these medications did not exist years ago, this quality of life. My oldest daughter is a melanoma survivor. It's a miracle. There is no two ways about it. When she was diagnosed the head of the department told me that I would need to take time off to be with her, which means she wasn't going to make it. She was young at the time, she had two babies, and she would say they have support groups for this and they have support groups for that, there aren't any for melanoma. I couldn't say that's because people don't survive it, Rebecca. She drove home with Walter and me from Colorado to help us make the trip, and she had annual checkup. She's cured; at nine years they finally said. They did her. But the point I'm making is when she was seeing her physician and talking to the people in the unit she noticed brochures and things that are offered now for these cancer patients that were not offered nine years ago. It just made her feel so good that these alternatives are there, and that things are there that are a big assistance."
[S.S.]"Again, with this esophageal thing, when my husband was diagnosed with this, we are talking, somebody who is a picture of hell and couldn't even believe it. They basically said you got a less than 5% chance of making it two years. To this day we've only met one other survivor of esophageal cancer."
"How long has it been?"
[S.S.]"It was five years May 12th. Even his gastroenterologist she says I'm not used to having people that keep checking up because they don't usually make it. It was one of those things that we went up to New York, he had the surgery, and the surgeon he was pretty positive. They just basically said you just take the best shot and just have to see what's going to happen. But the same thing, until this happened I had never heard of that. I knew no one to call. There was no support whatsoever. There was no literature anywhere around. There wasn't even this. That's one that I do notice about the Nexium,

the TV ad that they have for Nexium, which I would not have paid attention to prior to this happening to us, it actually shows the esophagus is healing. You see these big things are coming together and it's going to heal this thing. I can tell you what, having been through what I've been through that's a big difference."

DO YOU THINK THESE ADS CHANGE THE WAY WE THINK ABOUT OUR HEALTH?

"Oh, I do." (Several respondents agreed.)

[M.A.M.]"Makes you pay more attention to it. I think what's been brought up multiple times, if you have a specific problem, a pure migraine sufferer, the migraine one, hey this might help me or my friend."

[M.M.]"It's encouraging; it gets you hope."

[L.B.]"This is such a big part of it. You have to believe. If it's something life threatening you have to have hope, you have to have that encouragement."

[M.A.M.]"You start investigating." (One respondent agreed.)

[S.S.]"That's one of the first things too, is this is a help, the back thing here. Before they had these ads, where did you find this information? Ask your doctor." (One respondent agreed.)

[M.M.]"The Internet."

[N.M.]"Something like Viagra, that could be something you wouldn't discuss with anybody. But if you saw it in ad for it, I'm thinking a man would say well I'm just going to talk to my doctor about that. If they are talking about it, surely I can talk to my doctor about it."

HOW WOULD YOU EVALUATE YOUR RELATIONSHIP WITH YOUR DOCTOR?

[M.R.] "My present doctor, who I've seen twice, actually she's a PA. I've never seen the doctor that is my HMO principal. I wouldn't know him if I fell over him. Every time I go, and I've had a lot of health issues since I had my hip replaced. Dxxx Jxxxx, I will tell her name, I hope she's not here, gave me two days of pills, 11 pills in one dose. It nearly killed me. It was everything that I think everybody on the floor was taking. I had a violent reaction to it and I almost died. This was last year. So I'm very adversed to any sort of pills, except I have to take. I look at it and I pray. I pray for parking spaces. I pray for green lights. This is something that I plea for, let this work. I don't know if that's right. But I just had to rebuke all pills when I got so sick. Of course, pills were prescribed. That's when I was so sick. But that's why I'm real skidish about anything. I've had a lot of stuff wrong. But, I'm taking these pills. So, I've aware of these ads. I don't like to see them on TV. That's just my personal adverse reaction."

HOW COMFORTABLE ARE YOU ASKING YOUR DOCTOR ABOUT SOMETHING YOU'VE SEEN ADVERTISED?

[M.A.M.] "I'm comfortable." (Several respondents agreed.)

[M.M.]"Even if I don't know him."

[M.R.] "I go running in with all my little things written down so I won't forget them and run it by him."

IS THERE ANY SITUATION OR CONDITION YOU WOULD HAVE A DIFFICULT TIME DISCUSSING WITH YOUR DOCTOR?

[S.S.]"I'm a real strange person. I can ask anything about my children, my husband, whatever, but I cannot talk to my doctor or any doctor or anybody about myself. I sit there and I cannot do it."

[N.M.]"I have a female OB/GYN and I feel more comfortable with her."

[L.B.]"But, I don't go to doctors. Once a year for my annual exam, that's it." (One respondent agreed.)

[M.A.M.] "Well, I have just started with a new Internist because of my age. Everybody says well when you get 60 you need an Internist. Plus I did have a blood clot, so I was glad I had settled with him. He's like a Greek god. But, anyway he's great. He's in Jax Beach."

HAVE YOU EVER ASKED HIM FOR A PRESCRIPTION FOR SOMETHING YOU'VE SEEN ADVERTISED?

[S.S.]"I wouldn't."

[M.M.]"I have. I'm married to a younger man, so I got to keep up. I asked my doctor for Zyban to stop smoking. Then I liked it so much, after it was all over I wanted to stay on it. So she switched it to Wellbutrin, which is the same thing as Zyban, which is a mild antidepressant. She said, great." (Several respondents agreed.)

[M.M.] "It's wonderful."

[M.A.m.]"I don't look at ads much. When they come on television I mute it and go do something."

[N.M.]"I take Vioxx."

DID YOU ASK FOR THOSE?

[N.M.]"I said you've got to do something." (One respondent agreed.)

WOULD YOU SAY "I SAW THIS DRUG ADVERTISED AND I WOULD LIKE IT?"

[M.R.] "With Zoloft."

WHAT KIND OF REACTION DID YOU GET FROM YOUR DOCTOR?

[M.R.]"That is exactly what I was going to prescribe. I said, I need to come to you?" "I've asked about herbal things. They just look at you like. There's not been enough research done it. I can't recommend that."

[M.A.M.]"Actually my doctor just recommended an herbal thing. Condrotin, it's for arthritis."

[N.M.]"Well, there must be some research done on that."

WHAT IS YOUR DEFINITION OF THE CONCEPT OF GOOD HEALTH?

[M.M.]"It means waking up in the morning and feeling good and having energy."

[L.B.]"Feeling good from within, an adequate appetite, sleeping well. A good mental outlook."

[N.M.]"I would say about the same thing. When you get up you feel good mentally and physically. I'm a big believer in preventive medicine, so I try to do all my checkups with

the dentist, with the doctor. So, I feel like I need to do my part in keeping my body healthy, take my vitamins and calcium."
[M.R.]"I think living my life with joy. At the other end of the day going to bed and snuggling in and knowing that I'm going to be able to go to sleep."
[S.S.]"Pretty much feeling well, feeling like I can do the things that I want to do without any problems or anything like that, and I will be able to for a while. Not feeling bad about anything. I don't expect everything to be perfect to be a healthy person."
[M.A.M.]"Well all of that, and mentally and physically just feeling good and knowing. Nxxx mentioned the checkups and everything, as far as you know all the organs and everything are working and doing what they're supposed to do. Sleeping well, having energy and stamina. The attitude, that mental part."
[L.B.]"I had breast cancer. As far as I'm concerned I'm fine. I don't consider that an illness because as far as I'm concerned I'm better. I don't worry about it. But I don't consider myself to be in bad health because I've had that."

HOW WOULD YOU EVALUATE YOUR OWN PERSONAL HEALTH ON A SCALE OF ONE TO TEN COMPARED TO THE HEALTH OF YOUR FAMILY AND FRIENDS?
[M.R.]"Eight."
[L.B.]"From here to here I'm a healthy little old lady. My doctor said if we could fix this you may live to be a 120. I may anyway."
[N.M.]"I would say a nine. Compared to people my age that have arthritis, which I feel blessed not to have, and bad knees and all of that. I think I'm very healthy."
[M.R.]"I have been healthier. But I think really I'm coming back. I feel good when I get up in the morning. So, probably eight."
[S.S.]"Nine."
[M.M.]"You look like a nine."
"You look like a ten."
[M.A.M.]"I'd say a nine."

IF SOMEONE TOLD YOU THAT, BASED ON YOUR DECISION, WE'RE GOING TO ALLOW THIS FORM OF ADVERTISING TO INCREASE, DECREASE, OR LIMIT IT IN SOME WAY, HOW WOULD YOU PERSONALLY EVALUATE THIS FORM OF ADVERTISING?
[M.R.]"I'm glad that it is prescription because with these claims if I could just go and get, I might just go and get it and not worry about the consequences."

DOES THIS FORM OF ADVERTISING PROVIDE A USEFUL SERVICE OR NOT?
[M.R.]"I think it does to a point because it makes you aware that there is a solution perhaps for your ailment. As I said before, I think prescription drugs are good because you need a knowledgeable person, a doctor, in order to get the drug. I think it's important that we can't just go and buy it without more knowledge." (One respondent agreed.)

[M.A.M. "I think a drawback with it would be just because what we've talked about, everybody is on drugs. We depend so on them. This helps promote that. So that would be a negative part."

[S.S.]"I agree with you in that it promotes it to probably to excess for some people. You realize you're reaching a general audience. There are going to be some people that are just going to take and some that aren't. But what I do see a real value is just thumbing through here before this happened you never had pages that even told you what the side affects were. You depended totally on what you physician said to you, you take this, where as now you might read some of this stuff. If he said okay you need some Flonase, you said I see right here I've heard it does this, this and this, and how is this going to affect my other problem that I have that he doesn't even know about because you never told him. Physicians aren't mind readers, and I'm like I just told you the worst one around to even tell you."

[M.A.M.] "That Fosamax, I just remember seeing that advertised and scared me death because you can choke to death on it. You take it for your bones. If you can't take estrogen and you need something that will build bones, they give Fosamax. I can't be on estrogen. My doctor said isn't it dangerous. You better be sitting straight up, and not eat 30 minutes before. See that's what I get out of the ad, the scary part, because I don't like them anyway. It's something about how it's got to get down all the way into your system, and you can't be lying down because if it stops then it will eat a hole. It's scary." "I feel the same way about the herbal supplements that aren't regulated, so many of them aren't. They frighten me terribly."

[M.M.]"Look at the diet stuff."
[M.R.]"People mix them. I think that's very dangerous."
[S.S.]"Back to your original question, I do think the ads are valuable from the standpoint that it does give you an opportunity to sit down on your own time and read and find out stuff that you would not have found out so at least when you go to your physician you can ask a question." (One respondent agreed.)
[N.M.]"I'm glad it's regulated by prescription so that you can't go like the herbal." (One respondent agreed.)
[L.B.]"I think as long as they're regulated, because people would tend to just oh I'll try this, and I'll try that."

IS THIS A GOOD SOURCE OF INFORMATION?
"Excellent." (One respondent agreed.)
"To a point."

WHAT IS YOUR BEST SOURCE OF HEALTH INFORMATION?
[M.A.M.] "I think the Internet. It's just all out there now."
[N.M.]"I love the Mayo newsletter."
[M.A.M.] "I like what they give you now when you pick your drug up. It really is all spelled out." (One respondent agreed.)

[S.S.]"I do notice that almost all these ads do have an Internet site, most of them do. That actually is kind of valuable."
[L.B.] "I have a wonderful relationship with my physician. I depend solely on him."

THANK YOU.

REFERENCES

Adams, G. R., & Huston, T. L. (1975). Social perception of middle-aged persons varying in physical attractiveness. *Developmental Psychology, 11,* 656-658.

Administration on Aging. (2000). *A profile of older Americans: 2000.* Retrieved March 23, 2001, from http://www.aoa.dhhs.gov/aoa/stats/profile/2000/1.html

Administration on Aging. (2001). *A profile of older Americans: 2001.* Retrieved March 2, 2002, from http://www.aoa.dhhs.gov/aoa/stats/profile/2001/1.html

Adelman, R. D., Greene, M. G., Charon, R., & Friedman, E. (1990). Issues in the physician-geriatric patient relationship. In H. Giles, N. Coupland, & J. M. Wiemann (Eds.), *Communication, health and the elderly* (pp. 126-134). London: Manchester University Press.

Alper, P.R. (1999, October 6). Direct-to-consumer advertising: Education or anathema? [Letter to the editor]. *Journal American Medical Association, 282*(13), 1226-1227.

Anderson. W., & Wahler, R. (2001, January-February). Pharmacy management can reduce medicare—and human costs. *Aging Today.* Retrieved April 30, 2001, from http://www.asaging.org/at/at-217/Forum

Associated Press (2000, July 4). Most HMOs don't cover newer drugs. *Florida Times Union,* A10.

Atkinson, P., & Coffey, A. (2002). Revisiting the relationship between participant observation and interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context & method.* (pp. 801-814). Thousand Oaks, CA: Sage.

Barry, P. (2000, November). Hard pills to swallow. *AARP Bulletin,* [Electronic version]. Retrieved April 30, 2001, from http://www.aarp.org

Barry, P. (2002a, March). Ads, promotions drive up drug costs. *AARP Bulletin.* [Electronic version]. Retreived March 30, 2002 from, http://www.aarp.org

Barry, P. (2002b, April). AARP takes its drug initiative to Congress. *AARP Bulletin,* p. 2.

Barry, P. (2002c, July/August). Down-to-the-wire battle over drugs. *AARP Bulletin Online*. Accessed September 17, 2002, at http://www.aarp.org/bulletin

Becker, M. H. (1985). Patient adherence to prescribed therapies. *Medical Care, 23*(5), 539-555.

Beisecker, A. E., & Thompson, T. L. (1995). The elderly patient-physician interaction. In J. F. Nussbaum & J. Coupland (Eds.), *Handbook of communication and aging research* (pp. 397-416). Mahwah, NJ: Lawrence Erlbaum Associates.

Belkin, L. (2001, March/April). Primetime pushers. *Mother Jones*, 30-37.

Bell, R. A., Kravitz, R. L., & Wilkes, M. S. (2000) Direct-to-consumer prescription drug advertising, 1989-1998: A content analysis of conditions, targets, inducements, and appeals. *Journal of Family Practice, 49*(4), 329-335.

Bell, R. A., Wilkes, M. S., & Kravitz, R. L. (1999). Advertisement-induced prescription drug requests: Patients' anticipated reactions to physician who refuses. *Journal of Family Practice, 48,* 446-452.

Bell, R. A., Wilkes, M. S., & Kravitz, R. L. (2000). The educational value of consumer-targeted prescription drug print advertising. *Journal Family Practice, 49*(12), 1092-1098.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Englewood Cliffs, NJ: Prentice Hall.

Bultena, G. L. (1968). Age-grading in the social interaction of an elderly male population. *Journal of Gerontology, 23,* 539.

Bultena, G., & Powers, E. (1976). Effects of age-grade comparisons on adjustment in later life. In J. Gubrium (Ed.), *Times, roles, and self in old age*. New York: Behavioral Publications.

Burns, A. (1978). The perceived inter-relation of physical attractiveness, likability, and perceived age in women. *Dissertation Abstracts International, 38*, 6232B-6233B. (UMI No. 7808667)

Butler, R. (1969). Ageism: Another form of bigotry. *The Gerontologist, 9*, 243-246.

Carr, D.J. & Bowers, B.H. (2002). Recent development in learned intermediary doctrine. *The Brief*, Winter, 20-25.

Carter, J. (2002, February 28). Feds revise drug discount plan. *Washington Post.* Retrieved March 6, 2002, from http://www.washingtonpost.com

Castagnera, J. O., & Gerner, R. R. (2000, Fall). The gradual enfeeblement of the learned intermediate rule and the argument in favor of abandoning it entirely. *Tort & Insurance Law Journal*, 119-146.

CBS News. (2000, May 31). Patients driving higher drug costs [Electronic version]. Retrieved May 31, 2000 from http://cbsnews.cbs.com

Christensen, T. P., Ascione, F. J., & Bagozzi, R. P. (1997). Understanding how elderly patients process drug information: A test of the theory of information processing. *Pharmaceutical Research, 14*(11), 1589-1596.

Cooley, G.H., 1964. *Human nature and the social order.* New York: Scribners. (Original work published 1902)

Creagan, E. T. (Ed.). (2001). *Mayo clinic on healthy aging.* Rochester, MN: Mayo Clinic.

Dalzell, M.D. (1999, December). Direct-to-consumer advertising: Can everyone's interests be balanced? *Managed Care*, 28-35.

Davis, J. J. (2000). Riskier than we think? The relationship between risk statement completeness and perceptions of direct-to-consumer advertised drugs. *Health Communication*, 5, 349-369.

Davis, M. A., Moritz, D. J., Neuhaus, J., & Barclay, J. (1996). The influence of sociodemographic characteristics and morbidity as the likelihood of living alone among older U.S. adults who become unmarried: A comparison of men and women. *Journal of Women and Aging, 8*(2), 3-17.

Davis, N. M., & Cohen, M. R. (1992). Counseling reduces dispensing accidents. *American Pharmacy*, *NS32*(10), 22.

Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York: McGraw-Hill.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Dollemore, D. (Ed). (1999). The doctor's book of home remedies for seniors: An A-Z guide to staying physically active, mentally sharp and disease-free. Emmaus, PA: Rodale Press.

Dorschner, J. (2002, October 23). Viewers tune out drug commercials. *Miami Herald.* Retreived October 28, 2002 from http://www.miami.com

Doubilet, P., & McNeil, B.J. (1985). Clinical decision-making. *Medical Care, 23*(5), 648-662.

Downs, C. W., Smeyak, G. P., & Martin, E. (1980). *Professional interviewing.* New York: Harper and Row.

Drug Benefit Trends. (2000). Trend of the month: The elderly are hit hardest by rise in drug costs, 12(8), 6-7. Retrieved October 12, 2000, from http://www.medscape.com/SCP/DBT/2000/v12.n08/d1208.01.trend/pnt-d1208.01.trend.html

Drug Topics Archive. (2001, April 2). Behind the numbers. Retrieved from pdr.net/dt/public.htm?path=content/journals/data/2001/0402

Eisenberg, J. M. (1985). Physician utilization: The state of research about physicians' practice patterns. *Medical Care*, *23*(5), 461-483.

Elliott, V. S. (2001, July 9/16). Questions swirl around drug ads for patients. *American Medical News, 44*(26), 1-2.

Eraker, S. A., Kirscht, J. P., & Becker, M. H. (1984). Understanding and improving patient compliance. *Annals of Internal Medicine, 100,* 258-268.

Erlich, B. (2001). 35 seconds to DTC success. *DTC Perspectives, 1*(2), 10.

Ferguson, D. (2000, Fall). No such thing as a free lunch? Topics in internal medicine. *Residents Medical Journal, Mayo Clinic Jacksonville, 6*(1), 13.

Fox, M. (2001, November 29). Drug ads inform but don't educate, survey finds. abcNEWS.com. Retrieved November 29, 2001 from http://printerfriendly.abcnews.com

Freudenheim, M. (1998). The media business: Advertising, influencing doctor's orders. *The New York Times*, 11/17/98.

Friedan, B. (1993) *The fountain of age*. New York: Simon & Schuster.

Fry, V. H., Alexander, A., & Fry, D. L. (1989). The stigmatized self as media consumer. *Studies in Symbolic Interaction, 10,* 339-350.

Geist, P., & Hardesty, M. (1990). Ideological positioning in professionals' narratives of quality medical care. In N. K. Denzin (Ed.), *Studies in symbolic interaction* (pp. 257-284). Greenwich, CT: JAI Press.

Gemperli, M. (2000). Rethinking the role of the learned intermediary: The effect of direct to consumer advertising on litigation. *Journal American Medical Association, 284*(17), 2241.

Goebel, B. L. (1982). Age preferences of older adults in relationships important to their life satisfaction. *Journal of Gerontology, 37,* 461-467.

Goetzl, D. (2001, December 10). Ad age marketer of the year: Pfizer. *Advertising Age.* Retreived December 10, 2001, from http://www.adage.com/news

Goffman, E. (1959). *The presentation of self in everyday life.* Garden City, NY: Doubleday.

Goldstein, A. (2002, February 26). Prescription drug proposal spurs bidding. *Washington Post.* Retrieved February 26, 2002, from http://www.washingtonpost.com

Gonul, F. F., Carter, F., Petrova, E., & Srinivasan, K. (2001). Promotion of prescription drugs and its impact on physicians' choice behavior [Electronic version]. *Journal of Marketing, 65*(3), 79-90.

Graham, H. (1985). Providers, negotiators, and mediators: Women as the hidden carers. In E. Lewin & V. Olesen (Eds.), *Women, health, and healing: Toward a new perspective* (pp. 25-52). New York: Tavistock.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage.

Gubrium, J. F., & Holstein, J. A. (1997). *The new language of qualitative method.* New York: Oxford University Press.

Hadden, S. G. (1991). Regulating product risks through consumer information. *Journal of Social Issues, 47(1), 93-105.*

Halter, J. B. (1999). The challenge of communicating health information to elderly patients: A view from geriatric medicine. In D. C. Park, R. W. Morrell, & K. Shifren (Eds.), *Processing of medical information in aging patients: Cognitive and human factors.* Mahwah, NJ: Lawrence Erlbaum.

Ham, R. M., & Sloane, P. D. (1992). *Primary care geriatrics: A case-based approach.* St. Louis: Mosby Year Book.

Hammond, S. L. (1995). Supplementing health campaign messages: Recent developments in informing patients about their prescription drugs. In E. Maibach & R. L. Parrott (Eds.), *Designing health messages: Approaches from communication theory and public health practice* (pp. 249-269). Thousand Oaks, CA: Sage.

Hartley, J. (1999). What does it say: Text design, medical information and older readers. In D. C. Park, R. W. Morrell, & K. Shifren (Eds.), *Processing of idical information in aging patients: Cognitive and human factors* (pp. 233-248). Mahwah, N.J: Lawrence Erlbaum.

Haug, M. (1996). The effects of physician/elder patient characteristics on health communication. *Health Communication, 8*(3), 249-262.

Haug, M. R., & Ory, M. G. (1987). Issues in elderly patient-provider interactions. *Research on Aging, 9*(1) 3-44.

Herxheimer A., Lundborg, C. S., & Westerholm, B. (1993). Advertisements for medicines in leading medical journals in 18 countries: A 12-month survey of information content and standards. *International Journal Health Services, 23,* 161-172.

Hoffrage, U., Lindsey, S., Hertwig, R., & Gigerenzer, G. (2001). Communicating statistical information [Electronic version]. *Science Magazine, 290*(5500), 2261.

Hollon, M. F. (1999). Direct-to-consumer marketing of prescription drugs: Creating consumer demand. *Journal American Medical Association, 281*(4), 382-384.

Holmer, A. F. (1999). Direct-to-consumer prescription drug advertising builds bridges between patients and physicians. *Journal American Medical Association, 281*(4), 380-382.

Holstein, J. A., & Gubrium, J. F. (2000). *The self we live by: Narrative identity in a postmodern world.* New York: Oxford University Press.

Huang, A. (2000). The rise of direct-to-consumer advertising of prescription drugs in the United States. *Journal American Medical Association, 284*(17), 2240.

Johnson, G. L., & Ramaprasad, A. (2000). Patient-physician relationships in the information age. *Marketing Health Services, 20*(1), 20-27.

Kahn, C. (2001). How the media influences women's perceptions of health care. *Marketing Health Services, 21*(1), 12-17.

Kessler, D. A., & Pine, W. L. (1990). The federal regulation of prescription drug advertising and promotion. *Journal American Medical Association, 264,* 2409-2415.

Kovar, M. G. (1984). Aging in the eighties: Preliminary data from the supplement on aging to the National Health Interview Survey, United States, January-June 1984. *Advance Data From Vital and Health Statistics, No. 115* (DHHS Publication No. PHS 86-1250). Hyattsville, MD: Public Health Service.

Kravitz, R. L (2000). Direct-to-consumer advertising of prescription drugs: Implications for the patient-physician relationship. *Journal of American Medical Association, 284*(17) 2244.

Kuserow, R. P. (1990, November). *The clinical role of the community pharmacist.* Washington, DC: U.S. Government Printing Office.

Latner, A. W. (2000, April). Top 200 drugs of 1999. *Pharmacy Times*, 16-32.

Lincoln, Y. S. (1992). Sympathetic connections between qualitative methods and health research. *Qualitative Health Research, 2*(4), 375-391.

Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry, 1,* 275-289.

Lincoln, Y. S. (1998). From understanding to action: New imperatives, new criteria, new methods for interpretive researchers. *Theory and Research in Social Education, 26*(1), 12-29.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), (2000). *Handbook of qualitative research* (pp. 163-188). Thousand Oaks, CA: Sage.

Lindlof, T. R. (1995). *Qualitative communication research methods.* Thousand Oaks, CA: Sage.

Lipsky, M. S., & Taylor, C. A. (1997). The opinions and experiences of family physicians regarding direct-to-consumer advertising. *Journal of Family Practice, 45*(6), 495.

Manis, J. G., & Meltzer, B. N. (1972). *Symbolic interactions: a reader in social psychology.* Boston: Allyn and Bacon.

McCarthy, R. (1999a). Desperate remedies? Pill-splitting to shave pharmacy costs. *Drug Benefit Trends, 11*(12), 19,21.

McCarthy, R. (1999b). Drug innovation spurs high prices, more promotions. *Drug Benefit Trends, 11*(10), 22-23.

McCracken, G. (1988). *The long interview.* Thousand Oaks, CA: Sage.

McCracken, S. (1998, September, 29). Health News. *Washington Post*, p. 37.

McInturff, B. (2001, March 26). While critics may fret, public likes DTC ads. *Advertising Age,* p. 224.

Mead, G. H. (1934). *Mind, self and society.* Chicago: University of Chicago Press.

Medical Letter on Drugs and Therapeutics. (2000, July 10). 42(1082), 57-58.

Miles, M., & Huberman, A. (1984). *Qualitative data analysis*. London: Sage.

Mintzes, B., Barer, M. L., Kravitz, R. L., Kazanjian, A., Bassett, K., Lexchin, J., Evans, R.G., Pan, R., & Marion, S. A. (2002). Influence of direct to consumer pharmaceutical advertising and patients' requests on prescribing decisions: Two site cross sectional survey. *British Medical Journal USA, 324*(2), 204-205.

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology, 22,* 129-152.

Morgan, D. L. (2002). Focus group interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 141-159). Thousand Oaks, CA: Sage.

Morrow, D., & Leirer, V. O. (1999). Designing medication instructions for older adults. In E. Maibach & R. L. Parrott (Eds.), *Designing health messages: Approaches from communication theory and public health practice* (pp. 249-266). Thousand Oaks, CA: Sage.

National Center for Health Statistics. (1999). Health, United States, 1999 with health and aging chartbook. Retrieved April 1, 2002, from http://www.cdc.gov/nchs/releases99news/hus99.htm

National Institute for Health Care Management Foundation. (2001, November). Prescription drugs and mass media advertising, 2000. Retrieved May 10, 2001, from www.nihcm.org/mainframe

National Institute for Health Care Management Foundation. (2002, April). Prescription drug expenditures in 2001: Another year of escalating costs. Retrieved May 30, 2002 from http://www.nihcm.org

National Research Council (1989). *Improving risk communication*. Washington, DC: National Academy Press.

Newman, L. (2000). Avalanche of direct-to-consumer drug marketing brings new questions. *Journal of the National Cancer Institute, 92*(12), 964-965.

Ohliger, P. C. (1999). Final FDA guidance for direct-to-consumer advertising. *Drug Benefit Trends, 11*(11) 25-26.

Orodenker, S. Z. (1991). Family caregiving in a changing society: The effects of employment on caregiver stress. New York: Garland.

Park, D. C., Willis, S. L., Morrow, D., Diehl, M., & Gaines, C. L. (1994). Cognitive function and medication usage in older adults. *Journal of Applied Gerontology, 13*(1), 39-57.

Parrott, R. L., & Condit, C. M. (Eds.). (1996). *Evaluating women's health messages.* Thousand Oaks, CA: Sage.

Patterson, S. (2002, September 17). Cities poorest remain isolated. *Florida Times Union*, pp. A1, A9.

Pear, R. (2000, June 27). 17 percent increase in prescription drug costs hit elderly hardest, study finds. *New York Times*. Retreived August 27, 2000, from http://www.nytimes.com

Pear, R. (2001a, April 23). States creating plans to reduce drug costs. *New York Times.* Retrieved April 23, 2001, from http://www.nytimes.com

Pear, R. (2001b, May 8). Drug spending grows nearly 19%. *New York Times.* Retrieved May 8, 2001, from http://www.nytimes.com

Pear, R. (2002, Dec. 4). Investigators find repeated deception in ads for drugs. *New York Times*. Retrieved December 4, 2002, from http://www.nytimes.com

Pearlman, S. (1993). Late mid-life astonishment: Disruptions to identity and self esteem. In N. Davis, E. Cole & E. D. Rothblum (Eds), *Faces of women and aging.* New York: Haworth Press.

Perez v. Wyeth Laboratories, 734 A.2d 1245, 1257 (N.J., 1999).

Peterson, M. (2001, May 22). Doubts are raised on the safety of 2 popular arthritis drugs. *New York Times.* Retrieved May 22, 1001, from http://www.nytimes.com

Peterson, M. (2002) TV ads spur a rise in prescription drug sales. *New York Times*. Retrieved March 8, 2002, from http://www.nytimes.com

Petroshius, S. M., Titus, P. A., & Hatch, K. J. (1995, November-December). Physician attitudes toward pharmaceutical drug advertising. *Journal of Advertising Research*, 41-51.

Peyrot, M., Alperstein, N. M., VanDoren, D., & Poli, L. G. (1998). Direct-to-consumer ads can influence behavior. *Marketing Health Services, 18*(2) 26-32.

Pierce, P. F. (1996). When the patient chooses: Describing unaided decisions in health care. *Human Factors, 38,* 278-287.

Pleming, S. (2001, May 8). Report: Prescription drug spending rises in U.S. *abcNEWS.com*. Retrieved May 8, 2001, from http://abcnews.go.com/wire/US/reuters

Prevention. (1997). Navigating the medication marketplace: How consumers choose. A Joint Survey from Prevention Magazine and the American Pharmaceutical Association, 28-29.

Puckett, J. M., Petty, R. E., Cacioppo, J. T., & Fischer, D. L. (1983). The relative impact of age and attractiveness stereotypes on persuasion. *Journal of Gerontology, 38,* 340-343.

Quintiles International. (2001, February 8). Spending on consumer ads for drugs up in 2000. *Scott-Levin.* Retrieved May 12, 2001, from http://www.quintiles.com/about_quintiles_transnational/products_and_ser.../1,1828,180,00.htm

Relman, A. S. (2001). Separating medical education from pharmaceutical marketing. *Journal American Medical Association, 285*(15), 2009.

Roberto, K. (1996). Friendships between older women: Interactions and reactions. *Journal of Women and Aging, 8*(3/4), 55-73.

Rosenberg, J. (2000, April 3). Head to head struggle: Initial Celebrex, Vioxx ad spending, sales stunning. *Advertising Age*, s2.

Rosenblatt, R. A. (2000, January-February). Drug ad boom raises concern. *Aging Today.* Retreived April 20, 2001, from http://www.asaging.org/at/at-211/drug_ad.html

Rosner, F., Kark, P., Packer, S., Benneett, A., & Berger, J. (1999, October 6). Direct-to-consumer advertising: Education or anathema? *Journal American Medical Association, 282*(13), 1227.

Roter, D. L., Lipken, M. J., & Korsgaard, A. (1991). Sex differences in patients' and physicians' communication during primary care medical visits. *Medical Care, 29*(111), 1083-1093.

Roth, M. S. (1996). Patterns in direct-to-consumer prescription drug print advertising and their public policy implications. *Journal Public Policy & Marketing, 15*(1), 63.

Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data.* Thousand Oaks, CA: Sage.

Ryan, E. B., & Cole, R. L. (1990). Evaluative perceptions of interpersonal communication with the elderly. In H. Giles, N. Coupland, & J. M. Wiemann (Eds.), *Communication, health and the elderly* (pp. 173-188). London: Manchester University Press.

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), (2000). *Handbook of qualitative research.* (pp. 769-701) Thousand Oaks, CA: Sage.

Salthouse, T. (1991). Mediation of adult age differences in cognition by reductions in waking memory and speed of processing. *Psychological Science, 2,* 179-183.

Samuelson, R. J. (2000, September 25). It's more than a drug problem, *Newsweek*, 37.

Schommer, J. C. (2000). Pharmacists' new communication role: Explaining illness and medicine to patients. In B. B. Whaley (Ed.), *Explaining illness: Research, theory and strategies.* Mahwah, NJ: Lawrence Erlbaum.

Schwandt, T. A. (1996). Farewell to criteriology. *Qualitative Inquiry, 2,* 58-72.

Silverman, D. (2000). *Doing qualitative research: A practical handbook.* London: Sage.

Standard Rate and Data Service. (2002, April). Consumer Magazine Advertising Source, *84*(4), p. 412).

Steinman, M. A. (2000). Gifts to physicians in the consumer marketing era. *Journal American Medical Association, 284*(17), 2243.

Steinwachs, D. M. (2002). Pharmacy benefit plans and prescription drug spending. *Journal American medical Association, 288*(14), 1773-1774.

Sterling Drug Inc. v. Cornish, 370 F.2d 82, 85 (8th Circuit, 1966).

Stewart, D. W., & Martin, I. M. (1994). Intended and unintended consequences of warning messages: A review and synthesis of empirical research. *Journal Public Policy & Marketing, 13*(1), 1-19.

Stryer, D., & Bero, L. A. (1996) Characteristics of materials distributed by drug companies. *Journal General Internal Medicine, 11,* 575-583.

Tanner, L. (2001, June 18). Doctors debate ban on drug ads. *America Online.* Retrieved June 24, 2001, from http://aol.com

Tardy, R., & Hale, C. (1998). Bonding and cracking: The role of informal, interpersonal networks in health care decision making. *Health Communication, 19*(2), 151-173.

Teinowitz, I. (2002, June 17). GOP prescription plan calls for DTC ad study: Two-year analysis would look into marketing impact on health costs. *Advertising Age* [Electronic version]. Retrieved October 9, 2002, from http://www.adage.com/news

Terzian, T. V. (1999). Direct-to-consumer prescription drug advertising. *American Journal of Law and Medicine, 25*(1), 149-167.

Thorelli, H., & Thorelli, S. V. (1974). *Consumer information handbook: Europe and North America.* New York: Praeger.

Tucker, G. K., & Smith, M. C. (1987). Direct-to-consumer advertising: Effects of different formats of warning information disclosure on cognitive reactions of adults. *Journal of Pharmaceutical Marketing and Management, 2*(1), 27-41.

Tudiver, S. (2001). Advertising prescription drugs to consumers: Why mid-life women should be wary. *A friend indeed, 18*(1), 1-6.

United States General Accounting Office. (2002). *Prescription drugs: FDA oversight of direct-to-consumer advertising has limitations* (Publication No. GAO-03-177). Washington, DC: U.S. Government Printing Office.

Wade, V. A., Mansfield, P. R., & McDonald, P. J. (1989). Drug companies' evidence to justify advertising. *Lancet*, 2, 1261-1264.

Warren, C. A. (2002). Qualitative interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 83-101). Thousand Oaks, CA: Sage.

Wenger, G. C. (2002). Interviewing older people. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 259-278). Thousand Oaks, CA: Sage.

Wiemann, J. M., Gravell, R., & Wiemann, M. C. (1990). Communication with the elderly: Implications for health care and social support. In H. Giles, N. Coupland, & J. M. Wiemann (Eds.), *Communication, health and the elderly* (pp. 229-242). London: Manchester University Press.

Wilkes, M. S., Bell, R. A., & Kravitz, R .L. (2000). Direct-to-consumer prescription drug advertising: Trends, impact and implications. *Health Affairs, 19*(2), 110-28.

Wilkes, M. S., Doblin B. H., & Shapiro, M. F. (1992). Pharmaceutical advertisements in leading medical journals: Experts' assessments. *Annals Internal medicine, 116*, 912-919.

Williams, M. A., & Eickhoff-Shemek, J. (2002). Exercise and physical activity: What to recommend to older women. *Women's Health in Primary Care, 5*(10), 624-634.

Williams, J. R., & Hensel, P. J. (1995). Direct-to-consumer advertising of prescription drugs. *Journal of Health Care Marketing, 15*(1), 35.

Wilson, G. L., & Hanna, M. S. (1986). *Groups in context: Leadership and participation in small groups.* New York: Random House.

Woloshin, S., Schwartz, L. M., Tremmel, J., & Welch, H. G. (2001). Direct-to-consumer advertisements for prescription drugs: What are Americans being sold? *The Lancet, 358*(9288), 1141-1146.

Wood, J. T. (1994). *Who cares: Women, care and culture.* Carbondale and Edwardsville, IL: Southern Illinois University Press.

Yates, J. F. & Stone, E. R. (1992). Risk appraisal. In J. F. Yates (Ed.), *Risk-taking behavior* (pp. 49-85). Chichester, UK: Wiley.

Zwahr, M. D. (1999). Cognitive processes and medical decisions. In D. C. Park, R. W. Morrell, & K. Shifren (Eds.), *Processing of medical information in aging patients: Cognitive and human factors perspectives* (pp. 55-68). Mahwah, NJ: Lawrence Erlbaum.

BIOGRAPHICAL SKETCH

Judith Jopling Sayre was born December 16, 1944, in Memphis, Tennessee, the daughter of Wallace and Miriam Jopling. She graduated from high school in Lake City, Florida, attended Wesleyan College in Macon, Georgia, and then married and raised a family. In 1978 she graduated from Troy State University, majoring in journalism and fine arts. She received her Master of Arts in Journalism and Communication in 1983 from the College of Journalism and Communication at the University of Florida. After a career in hospital public relations and advertising, she began teaching, first at Baylor University, in Waco, Texas, and then at the University of North Florida, where currently she is an Instructor in the Department of Communications and Fine Arts. Her research interests center on health communication and include patient/physician communications, public health campaigns, and aging issues in health care.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Deborah M. Treise, Chair
Professor of Journalism and Communications

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Kim Walsh-Childers
Associate Professor of Journalism and Communications

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Michael Weigold
Associate Professor of Journalism and Communications

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Donna Berardo
Associate Professor of Pharmacy Health Care Administration

This dissertation was submitted to the Graduate Faculty of the College of Journalism and Communications and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

May 2003

Dean, College of Journalism and Communications

Dean, Graduate School